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	155782	A. BUILDING 00 B. WING	12/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN 47960

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 11, 12, 13, 14, 17, 18, 19, and 21, 2012 Facility number: 012355 Provider number: 155782 AIM number: 201014410 Survey Team: Regina Sanders, RN TC (December 11, 12, 13, 14, 17, 18, and 21, 2012) Shannon Pietraszewski, RN (December 11, 12, 13, 14, 18, and 19, 2012) Amber Bloss (December 11, 12, 14, 17, 18, and 19, 2012) Census bed type: SNF: 36 SNF/NF: 19 Residential: 34 Total: 89 Census payor type: Medicare: 18 Medicaid: 15 Other: 56 Total: 89 These deficiencies reflect State	F0000	Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. Please acccept this plan as same and our credible allegation of compliance.White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings cited in accordance with 410 IAC 16.2. Quality review completed on December 3, 2012, by Janelyn Kulik, RN.			

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to inform residents of the services available in the facility and charges for such services not covered by Medicare when presented with their ABN (Notice of Medicare Non-Coverage) and failed to provide documentation indicating timely notification of the ABN notice, for 3 or 3 residents reviewed. (Residents #16, #42, and #59 Findings include: 1) During record review on 12-17-12 at 10:10 AM, the ABN's (Notices of Medicare Non-Coverage) for Resident #42, Resident #59, and Resident #16 did not include any documentation that potential costs of services after	F0156	1. Residents # 42, #59 and #16 have been discharged from Medicare services. No adverse affects were noted.2. Residents being discharged from Medicare services have the potential of being affected by this alleged deficient practice. Business Office Manager (BOM) has been in-serviced on appropriate documentation for Notices on Medicare Non-Coverage (ABN's) including providing rates/charges, obtaining a date from the person signing the ABN and meeting the required minimum of 2 day notice.3. BOM has been in-serviced on appropriate documentation for Notices on Medicare Non-Coverage (ABN's) including providing rates/charges, obtaining a date from the person signing the ABN and meeting the required minimum of 2 day notice.4. Audits of the ABN's will be done monthly x 6 months by	01/20/2013

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	the date of Non-Medicare Coverage was reviewed with those residents. During an interview on 12-17-12 at 12:30 PM, Employee #1 (Business Office Manager) stated she did not have documentation that a list of potential costs were presented to residents upon notice of being discharged from Medicare coverage. 2) During record review on 12-17-12 at 10:10 AM, the ABN's (Notice of Medicare Non-Coverage) did not indicate the required 2 day notice had been given for Resident #42, Resident #59, and Resident #16. The ABN for Resident #42 indicated the effective date of coverage for current skilled nurses services ended 7-5-12. The notification date of the ABN was unknown as Resident #42 signed the form but did not date it. The ABN for Resident # 59 indicated the effective date of coverage of services was ending on 8-8-12. The notification date of the ABN was unknown as Resident #59 signed the form but did not date it. The ABN for Resident #16 indicated the effective date coverage of current skilled nursing services would end		Home Office Business Support person or designee.Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA committee x 6 months or until 100% compliance is achieved.	

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	9-21-12. The facility failed to give Resident #16 the required minimum of 2 day notice as Resident #16 signed the ABN on 9-20-12. 3.1-4(a)			

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F0176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to assess the resident for self administration of respiratory medications for 1 of 1 residents reviewed for self medication administration. (Resident #67) Findings include: Resident #67's clinical record was reviewed on 12/13/12 at 2:49 p.m. Resident #67's diagnoses included but were not limited to, atrial fibrillation (irregular heart beat), hypertension, COPD (Chronic Obstructive Pulmonary Disease), and dementia. The Quarterly Minimum Data Set Assessment, dated 09/13/12, indicated the resident's was cognitively impaired. There was a lack of documentation to indicate the resident had a Self Administration of Medication assessment completed.	F0176	1. Resident #67 no longer resides at facility.2. Residents receiving respiratory medications have potential to be at risk of alleged deficient practice. Incorrect policy was provided to state survey team during the time of the survey. Residents receving respiratory medications will be assessed for self medication administration. Any changes will be documented and implemented accordingly.3. Licensed nurses will be in-serviced on Respiratory/Inhalation Treatment Guidelines which is the current policy the facility follows. It indicates that "if a resident is stable receiving the treatment the nurse does not need to remain in the room during the entire administration of the treatment." Director of Health Services (DHS) or designee will conduct respiratory treatment observations on various shifts 3x's/ week x 1 month, weekly x 1 month, then monthly monthly x 4 months. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	01/20/2013

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	On 12/13/12 at 4:00 p.m., LPN #3 was observed initiating Resident #67's Levalbuterol 1.25 mg/3 ml nebulizer (breathing) treatment (ordered 6/15/12) and left the room while the machine was running and the breathing treatment mask was on the resident's face. LPN #3 returned to give medication and left the room again. LPN #3 went into two other resident's room for assessment and medication administration before returning to Resident 67's room and indicated to her "5 more minutes" and she will be back. Interview with LPN #3 at this time indicated the resident can be left alone while the nebulizer machine was running. On 12/14/12 at 9:49 a.m., LPN #4 was observed initiating Resident #67's Levalbuterol 1.25 mg/3 ml nebulizer treatment and left room while machine was running. At 9:54 a.m., Resident #67 was observed to be coughing hard while the breathing treatment mask was on the face. LPN #4 was observed returning to the room after 10:00 a.m. before turning off the nebulizer machine. Interview with LPN #4 at this time			

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	indicated the resident can be left alone while the nebulizer machine was running. A facility policy, undated and provided by the Director of Nursing on 12/14/12 at 11 a.m., indicated "...residents requesting to self medicate or has self medication as a part of their plan of care shall be assessed for safety by a licensed nurse. Results of the assessment will be presented to the physician for evaluation and an order for self administration..." A Specific Medication Administration Procedures policy dated 2/1/10 was provided by the Consultant on 12/14/12 at 10:50 a.m. The Consultant indicated this was the only policy she could find regarding nebulizer's. The policy indicated "...Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer, approximately five minutes after treatment begins (or sooner if clinical judgement indicates) obtain the resident's pulse, monitor for medication side effects, including rapid pulse, restlessness and nervousness throughout the treatment.			

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	The December 2012 Physician Recapitulation Orders did not indicate the resident was able to self administer her own nebulizer treatments. 3.1-11(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure all residents had been served lunch prior to removing food from the serving table and failed to ensure a resident was in clean pants prior to going to breakfast in 2 of 6 residents observed for dignity. (Resident #24 and #95) Findings include: 1. Lunch service was observed on 12/11/12 from 12:30 to 1:00 p.m. Resident #95 was observed sitting at his table without his lunch. Resident #95 indicated he had not received his lunch and questioned when he would receive it. Dietary and CNA#8 was observed to be removing food from the steam table and dishes from other resident tables. Interview with CNA #8 during this time indicated she was not aware the resident had not received his lunch due to his lunch ticket was not available. 2. On 12/13/12 at 8:30 a.m., Resident #24 was observed in her	F0241	1. Resident #95 received his lunch during the time of the survey. He ordered a "special" that was prepared in the kitchen and, therefore, didn't need to receive any food from the steam table. Resident #24 was provided clean pants during the time of the survey. No adverse affects were noted.2. Residents receiving meals in the dining room have the potential to be affected by the alleged deficient practice. Dietary and Nursing staff will be in-serviced on verifying residents present in the Dining Room receive their food before the food is removed. Nursing staff will also be in-serviced on dignity issues related to residents' hair being combed and clothing not being soiled. 3. Meal Manager or designee will conduct audits 3x's/week x 1month, then weekly x 5 months to ensure all residents in the Dining Room receive food prior to food being removed and that residents are in unsoiled clothing with combed hair. 4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is	01/20/2013

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	wheel chair in the front lounge with her hair not combed and pants soiled/stained in between her legs. The resident was observed being assisted to the Dining Room for breakfast and then returned to Unit Lounge. Resident was observed at 10:30 a.m. with same pants on. Interview with CNA #8 during this time indicated resident should have clean pants on. 3.1-3(t)		achieved.	

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure Social Services assisted with planning care related to 1 of 1 resident reviewed with delusions. (Resident #46) Findings include: A clinical record review on 12/14/12 at 9:08 A.M. indicated Resident #46's diagnoses included, but were not limited to dementia with behavioral disturbances, depression, hemorrhagic cystitis, Alzheimer's, and stroke. A Behavioral Health Consult, dated 3/7/12, indicated, "staff reports that (Resident Name) is having difficulties with delusions. He reported that he believes that the nursing home is actually a brothel and prostitution occurs there ....He also expressed these delusions to this writer. In addition, he frequently accuses staff of stealing his things. " A psychiatry consultation on 4/25/12	F0250	1. Social Services Director (SSD) developed care plans related to delusions and false accusations for Resident # 46 at the time of the survey. No adverse affects were noted.2. Residents exhibiting delusions and/or false accusations have potential for this alleged deficient practice. SSD or designee will review all charts of current residents to ensure those exhibiting delusions and/or false accusations have care plans.3. SSD will be in-serviced on the necessity of care plan documentation related to delusions and/or false accusations. 4. Minimum Data Set Coordinator (MDSC) or designee will audit care plans are in place for residents exhibiting delusions and/or false accusations in conjuction with care planning schedule. MDSC will audit with each MDS due date.Audit results will be brought to monthly Quaility Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	01/20/2013

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	indicated Resident #46 had thought processes with "occasional paranoid delusions." The consultation recommended a goal for Resident #46 to continue on Seroquel (antipsychotic) (which began on 3/20/12 at 12.5 mg a.m. and 50 mg at bedtime) with "no change at present to stabilize mood and avoid any increase in psychosis." The clinical record review indicated that Resident #46 had a care plan for psychotropic drug use (dated 6/20/12), psychosocial problems (11/13/12), impaired decision making (9/7/12), cognitive function (9/7/12), depression (6/13/12), communication (6/13/12), and behavior (6/13/12) The care plan lacked documentation to indicate the resident had delusions and/or false accusations. On 12/17/12 at 11:01 A.M. during an interview with the Social Service Director (Employee #2), she indicated delusions had not been care planned but she thought it should have been. 3.1-34(a)			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on record review and interview, the facility failed to thoroughly and accurately assess residents with the MDS (Minimum Data Set) Assessments, related to	F0272	1. Resident #33 has had updated Minimun Data Assessment (MDS) and care plans updated. Resident #35 will have Elimination Circumstance Form initiated and updates will be made	01/20/2013

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	155782	A. BUILDING 00 B. WING	12/21/2012

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	pressure ulcers and urinary incontinence, for 2 of 19 residents reviewed for assessments. (Residents #33 and #35) Findings include: 1. Resident #33's record was reviewed 12/12/12 at 5:30 p.m.. The resident's diagnoses included, but were not limited to, failure to thrive and congestive heart failure. The Quarterly MDS Assessment, dated 09/04/12, indicated the resident had one stage one (intact skin with non-blanchable redness) pressure area and one stage two (partial thickness loss of dermis) pressure area, and no unstagable pressure areas. The care plan, dated 07/30/12, indicated the resident had a pressure ulcer on the right heel. The interventions included to assess the pressure area per schedule. The Pressure Ulcer Assessment form, indicated the assessment size of the right heel pressure ulcer, during the MDS Assessment period, on 08/30/12 was a stage two (the stage two had been marked over and an "E" (unstagable) was written over it. The		accordingly. Residents #33 and #35 had no adverse affects related to alleged deficient practice. 2. Residents with pressure ulcers and changes in urinary incontinence have potential of being at risk of alleged deficient practice. Pressure ulcer documentation will be compared to Minimum Data Assessment (MDS) coding for current residents that have pressure ulcers.Corrections to MDS will be sumbitted as necessary. Any residents who experienced a change in incontinence based on MDS Assessments and feedback from nursing staff within the last 30 days will have documentation reviewed to ensure an assessment was completed. If an assessment is not documented, one will be completed. 3. Wound nurse or designee will be in-serviced on appropriate documentation protocol and assessment of pressure ulcers. Nursing staff including Minimum Data Set Assessment Coordintaor (MDSC) will be in-serviced on necessary assessment documentation with changes in urinary incontinence. Certified Resident Caregiver Associates (CRCA's) will communicate increased episodes of incontinence to the nurse who will initiate an Elimination Circumstance Form. If necessary, a 72 hour Elimination Record/Schedule will also be	

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	size was 4 cm (centimeters) by 7 cm with a depth of 0.2 cm. The color of the wound was marked as, "R (red)/P (purple)/Y (yellow) (slough)", and had irregular wound margins. During an interview on 12/13/12 at 1:20 p.m.- MDS LPN indicated the assessment of wound was marked with as a stage two by the nurse who assessed it and another nurse marked over it and coded it unstagable ("E"). She indicated the assessment was not correct, but the correction on the form occurred after she had completed the MDS Assessment. 2. Resident #35's record was reviewed on 12/17/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to hypertension and dementia. The Admission MDS Assessment, dated 09/21/12, indicated the resident was continent of urine. A Significant Change MDS Assessment, dated 10/22/12, indicated the resident was frequently incontinent of urine. There was a lack of documentation an assessment had been completed		inititated to determine patterns of incontinency and if a toileting schedule will prevent incontinency.4. MDSC and wound nurse or designees will compare pressure ulcer documentation to MDS coding at time of MDS reference period for all residents with pressure ulcers to ensure accuracy x 6 months. DHS or designee will ensure any residents experiencing changes in urinary incontinence have an Elimination Circumstance Form completed with each change identified. This will be done 5 x's/week x 1 month, then 3x's/week x 1 month, then weekly x 4 months. Audit results will be brought to Quality Assurance (QA) meetings monthly. Trends will be reviewed by QA Committe x 6 months or until 100% compliance is achieved.	

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	with the Significant Change MDS Assessment to indicate the reason for the incontinency, type of incontinency, patterns of incontinency, and for a personal toileting schedule to prevent incontinency. During an interview on 12/17/12 at 11:50 a.m., the MDS LPN indicated a Significant Change MDS Assessment had been completed because the resident had a fall and had declined and that was when the incontinency started. 3.1-21(a) 3.1-21(b)			

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F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to develop care plans for 6 out of 10 residents reviewed for unnecessary medications who were taking medications known to thin the blood and possibly cause bruising and 1 of 1 residents reviewed for behaviors. (Residents #12, #28, #36, #40, #46, #51, and #57) Findings include: 1. Resident #36's clinical record was	F0279	1.Care plans were developed for Residents #12, #28, #36, #40, #46, #51 and #57. No adverse affects were noted.2. Residents who take medications known to thin blood and possibly cause bruising and residents who exhibit delusions and/or false accusations have potential of being at risk of alleged deficient practice. Care plans of residents with these factors have been reviewed. Care plans have been initiated accordingly. All new admissions and residents with medication changes will have care plans developed accordingly in compliance with due date of	01/20/2013

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	reviewed on 12/13/12 at 9:30 a.m. Resident #36's diagnoses included but were not limited to COPD (chronic obstructive pulmonary disease/lungs), steroid induced osteoporosis, lupus, and anemia. The 12/2012 Physician Recapitulation orders indicated the resident took prednisone (steroid) 10 mg (milligrams) and Plavix (antiplatelet/blood thinner) 75 mg on a daily basis. During an interview with Resident #36 on 12/11/12 at 2:15 p.m., bruises were observed on the top of her bilateral hands. The resident indicated she had lupus and she gets bruises all the time. Interview with the Nurse Consultant on 12/14/12 at 10:30 a.m., she indicated there were no skin sheets/assessments found in a skin/wound binder located at the nurses station. The care plan, dated 11/27/12, lacked documentation to indicate the resident had a care plan for the prednisone and Plavix therapy and the risk of bruising. 2. Resident #12's clinical record was		care plans.3. Minimum Data Set Assessment Coordinator (MDSC) and Social Services Director (SSD) will be in-serviced on necessity of developing care plans for residents with these factors. MDSC will review diagnosis' and behavior coding on MDS in comparison to care plans at the time of each MDS. Director of Health Services (DHS) or designee will audit that care plans are in place for residents who take medications known to thin blood and possibly cause bruising and residents who exhibit delusions and/or false accusations as changes in medications occur and/or new onset of delusions and/or false accusations occur and/or with new admissions. 4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	reviewed on 12/17/12 at 11:00 a.m. Resident #12's diagnoses included but were not limited to, arteriosclerosis, chronic right leg pain, COPD (chronic obstructive pulmonary disease/lungs), PVD (peripheral vascular disease), CVA (cerebral vascular accident/stroke) with hemiplegia (paralysis), and a vertebral compression fracture. The 12/2012 Physician Recapitulation Orders indicated the resident took Plavix 75 mg for DVT (deep vein thrombosis/blood clot) on a daily basis. The care plan, dated 08/14/12, lacked documentation to indicate the resident had a care plan for the Plavix therapy and the risk of bruising. 3. Resident #57's clinical record was reviewed on 12/17/12 AT 2:00 p.m. Resident #57's diagnoses included but were not limited to Parkinson's Disease, CAD (coronary artery disease), anemia, and arthritis. The 12/2012 Physician Recapitulation orders indicated the resident took Plavix 75 mg daily for anti-platelet and aspirin 325 mg two times daily for heart health.			

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	A care plan was initiated 9/18/12 for the resident being at risk for bleeding related to anticoagulant use, but this care plan was discontinued with an unknown date. On 12/11/12 at 11:00 a.m., the resident was observed to have nickel size bruises located on the inner part of her bilateral upper arms. The care plan, dated 09/18/12, lacked documentation to indicate the resident had a care plan for the aspirin and Plavix therapy and the risk of bruising. Interview with the MDS (Minimum Data Set) LPN on 12/14/12 at 11:15 a.m. indicated she had never considered residents who take prednisone, Plavix, or aspirin as a possible blood thinning agent and has never wrote care plans for them. She indicated the medications can cause bruising. She indicated the care plan was discontinued when the resident's Coumadin (blood thinner) was discontinued. 4. During an observation on 12/11/12 at 11:44 a.m., Resident #51 was observed to have a bruise on the back of her left hand.			

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	Resident #51's record was reviewed on 12/14/12 at 3:30 p.m.. The resident's diagnoses included, but were not limited to, hypertension and stroke. A Skin impairment circumstance investigation, dated 2/7/12, indicated the resident had a bruise on the back of her right hand, which measured 5 cm (centimeters) by 5.5 cm. The form indicated the bruise was caused by a blood draw for a laboratory test. The Physician's Recapitulation Orders, dated 12/12, indicated the resident was receiving ASA (aspirin) 81 mg (milligrams) daily. The care plan, dated 11/05/12, lacked documentation to indicate the resident had a care plan for the aspirin therapy and the risk of bruising. During an interview on 12/14/12 at 1:45 p.m., the MDS LPN indicated she does not do a care plan for aspirin. She stated, "in my opinion, it is a low dose of aspirin and is not a risk for bleeding". She indicated she had not consulted with the pharmacy for risks of taking aspirin daily. A Profession Resource, titled, "2010			

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	Nursing Spectrum Drug Handbook" indicated, "...ASA...Contraindications...Hemorrhagic states or blood coagulation defects...Be aware that aspirin should be discontinued at least 1 week before surgery because it inhibit platelet aggregation...Adverse reactions...bruising..." 5. During an observation on 12/12/12 at 9:13 a.m., Resident #28 was observed to have a purple discoloration on her left lower leg. During an interview at the time of the observation, Resident #28 indicated she was unaware of what caused the purple discoloration. During an observation on 12/13/12 at 4:14 p.m., a bruise was observed on the resident's right upper arm. The resident indicated she did not know how the bruise occurred. Resident #28's record was reviewed on 12/14/12 at 8:19 a.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease and stroke. The Physician's Recapitulation Orders, dated 12/12, indicated the resident received aspirin 81 mg daily.			

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	The resident's care plan, dated 11/24/12, lacked documentation of aspirin therapy and the risk for bruising. 6. Resident #40's record was reviewed on 12/14/12 at 2 p.m. The resident's diagnoses included, but were not limited to, stroke and hypertension. The Physician's Recapitulation Orders, dated 12/12, indicated an order on 08/25/12 for Plavix (anti-blood clotting medication) 75 mg daily. The resident's care plan, dated 11/09/12, lacked documentation to indicate the resident was receiving Plavix therapy and the risks from the medication. During an interview on 12/17/12 at 8:16 a.m., the MDS LPN indicated there was no care plan for the Plavix because it was like aspirin it is low dose, so there was no problems or risks with taking it. A facility Professional Resource, titled, "Nursing Drug Handbook 2012", indicated, "Plavix...ADVERSE REACTIONS...bruising..."			

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	7. A clinical record review on 12/14/12 at 9:08 A.M. indicated Resident #46's diagnoses included, but were not limited to dementia with behavioral disturbances, depression, hemorrhagic cystitis, Alzheimer's, and stroke. A Behavioral Health Consult, dated 3/7/12, indicated, "staff reports that (Resident Name) is having difficulties with delusions. He reported that he believes that the nursing home is actually a brothel and prostitution occurs there ....He also expressed these delusions to this writer. In addition, he frequently accuses staff of stealing his things. " A psychiatry consultation on 4/25/12 indicated Resident #46 had thought processes with "occasional paranoid delusions." The consultation recommended a goal for Resident #46 to continue on Seroquel (antipsychotic) (which began on 3/20/12 at 12.5 mg a.m. and 50 mg at bedtime) with "no change at present to stabilize mood and avoid any increase in psychosis." The clinical record review indicated that Resident #46 had a care plan for psychotropic drug use (dated 6/20/12), psychosocial problems			

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	(11/13/12), impaired decision making (9/7/12), cognitive function (9/7/12), depression (6/13/12), communication (6/13/12), and behavior (6/13/12) The care plan lacked documentation to indicate the resident had delusions and/or false accusations. On 12/17/12 at 11:01 A.M. during an interview with the Social Service Director (Employee #2), she indicated delusions had not been care planned but she thought it should have been. 3.1-35(a)			

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise and update care plans related to dialysis, activities, medications, nutrition, oxygen, and oral care for 2 of 19 residents reviewed for care plans. (Residents #13 and #95) Findings include: 1. Resident #95's record was reviewed on 12/17/12 at 8:28 a.m. The resident's diagnoses included, but were not limited to, renal dialysis and kidney disease. The resident was admitted into the facility on 11/26/12.	F0280	1. Residents #13 and #95 no longer reside at the facility.2. Care plans of current residents related to dialysis and nutrition will be reviewed for accuracy. Any updates will be made as necessary. 3. Minimum Data Set Assessment Coordinator (MDSC) will be in-serviced on developing accurate care plans based on choosing correct care plan type and non-compliance of physician's orders by family or resident.4. Care plans will be updated as needed and audited by MDSC with each MDS x 6 months.Director of Health Services (DHS) or designee will audit that updated care plans	01/20/2013

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	The Admission Nursing Assessment, dated 11/26/12, indicated the resident had a right clavicle subclavian (large vein) dialysis access site. A care plan, dated 12/05/12, indicated the resident had an AV (arterial/ventricle) fistula (dialysis access site) and the staff were to monitor the bruit/thrill (vibration of the fistula). During an interview on 12/17/12 at 9:43 a.m., the Minimum Data Set (MDS) LPN indicated she thought the resident had a fistula. 2. Resident #13's clinical record was reviewed on 12/13/12 at 10:16 a.m. Resident's #13's diagnoses included but were not limited to, dementia with behaviors, hypertension, and chronic renal insufficiency. A care plan was initiated on 6/25/12 and updated 9/23/12 for anemia. The interventions indicated, assess and monitor for signs and symptoms of bleeding, replacement therapy to combat specific deficiency (iron, vitamins, B 12, folic acid, ascorbic acid), monitor labs and notify physician if abnormal.		are completed with new physician's orders 5 x's/week x 1 month, then 3x's/week x 1 month and then weekly x 4 months. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A CBC (complete blood count) was done on 8/23/12. The results indicated a platelet count of 118 L (low). Normal range was (150-450). A CBC was done on 6/25/12. The results indicated a normal platelet count of 287. The care plan was not updated indicating the resident was not taking supplements or vitamins and also of the family had refused to treat the low platelet count. 3.1-35(d)(2)(B)			

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	155782	A. BUILDING 00 B. WING	12/21/2012

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed, related to fluid restriction for 2 of 2 residents reviewed for fluid restriction. (Residents #57 and #95) Findings include: 1. Resident #95's record was reviewed on 12/17/12 at 8:28 a.m. The resident's diagnoses included, but were not limited to, renal dialysis and kidney disease. A physician's order, dated 12/07/12, indicated to limit the resident's fluids to one liter (1000 cubic centimeters) (cc) per day. The resident's fluid intake record the following daily intakes: 12/08/12-1440 cc 12/09/12-1710 cc 12/10/12-1380 cc 12/11/12-1120 cc 12/12/12-1140 cc 12/13/12-1230 cc 12/14/12-900 cc	F0282	1. Physician has been notified regarding non-compliance with fluid restriction for Resident #57. Resident #95 no longer resides at the facility. No adverse affects were noted.2.Residents with physician orders for fluid restriction have potential to be at risk of alleged deficient practice.Charts of current residents with physician's orders for fluid restriction will be reviewed for compliance and appropriate documentation. Self Determination of Care forms will be initiated for those residents who are non-compliant.3. Nursing staff will be in-serviced on policy for Guidelines for Fluid Restriction. Nurse will document any non-compliance related to physician orders and notify DHS or designee.4. DHS or designee will review fluid consumption for each resident with physician's order for fluid restriction 5 x's/week x 2 weeks, then 3x's/week for 2 weeks, weekly x 2 months, then monthly x's 3 months to ensure compliance. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is	01/20/2013

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	12/15/12-1660 cc 12/16/12-1224 cc During an interview on 12/17/12 at 8:45 a.m., LPN #11 indicated the resident can have 90 cc of fluid with each medication pass. She indicated the CNA's know the resident is on a fluid restriction. During an interview on 12/17/12 at 9:29 a.m., the Dietary Manager indicated the resident received 213 cc's per meal. An undated facility policy, received from the Administrator as current on 12/17/12 at 2:11 p.m., titled, "Guidelines for Fluid Restriction", indicated, "...Fluid consumption shall be reviewed each shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluid needs..." 2. Resident #57's clinical record was reviewed on 12/17/12 at 2:00 p.m. Resident #57's diagnoses included but were not limited to Parkinson's Disease, CAD (coronary artery disease), anemia, and arthritis. The 12/2012 Physician Recapitulation orders indicated the resident was on a		achieved.	

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	1000 ml (milliliters) fluid restriction. A care plan was initiated on 9/18/12 indicated the resident was at risk for dehydration related to a fluid restriction. The interventions indicated a 1000 ml (milliliters) fluid restriction per day. On 12/18/12 at 8:45 a.m., an interview with the Dietary Manager indicated she was given a communication form indicating how much fluid was to be provided with each meal. During this time, a dietary communication form was provided with a starting date of 3/3/12 indicating 220 ml with each meal and 80 ml "x 4 med (medication)" passes. An intake record was reviewed on 12/18/12 at 12:30 p.m. Between 10/14/12 to 10/31/12, the resident had consumed over 1000 ml of fluid for 14 out of 18 days. Between 11/1/12 to 11/30/12, the resident had consumed over 1000 ml of fluid for 23 out of 30 days. Between 12/1/12 to 12/17/12, the resident had consumed over 1000 ml of fluid 13 out of 17 days. An interview with the ADON (Assistant Director of Nursing) during this time indicated the resident was non compliant with her fluid restriction and there should be documentation by the staff when the			

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	resident was non compliant. The clinical record lacked documentation to indicate the resident was non-compliant with the fluid restriction. An undated facility policy, received from the Administrator as current on 12/17/12 at 2:11 p.m., titled, "Guidelines for Fluid Restriction", indicated, "...Fluid consumption shall be reviewed each shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluid needs..." A Guideline for Fluid Restriction was provided by the Administrator on 12/18/12 at 3:00 p.m. The guidelines indicated "...Intake and output monitoring shall be initiated upon receipt of the order. Fluid consumption shall be reviewed by shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluid needs. Should the resident and/or responsible party chose not to comply with the recommended fluid restriction, a Self Determination of Care form should be completed explaining the risk(s) of noncompliance. If the resident and/or			

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	responsible party continues to refuse recommended care intervention after the risk(s) have been explained, an order should be obtained to discontinue the fluid restriction. The resident should be periodically assessed for appropriateness and continued need for fluid restriction..." 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to provide necessary care and services, related to dialysis management for 1 of 2 resident reviewed for fluid restrictions (#95), pain management for 1 of 2 residents reviewed for pain management (Resident #12), and checking a pulse prior to medication administration for 1 of 1 residents observed for digoxin (heart medication) administration. (Resident #56). Findings include: 1. Resident #95's record was reviewed on 12/17/12 at 8:28 a.m. The resident's diagnoses included, but were not limited to, renal dialysis and kidney disease. The resident was admitted into the facility on 11/26/12. The Admission Nursing Assessment, dated 11/26/12, indicated the resident had a right clavicle subclavian (large	F0309	1. Resident # 95 no longer resides at facility. Resident #56 had no adverse affects noted. Resident #12 had no adverse affects noted. Resident #12 will have a pain assessment completed.2. Residents receiving dialysis services, residents with physician's orders for fluid restriction, residents receiving medications that require checking a pulse prior to administration and residents experiencing pain have the potential to be at risk of alleged deficient practice. Residents receiving dialysis services will have vascular access site assessed and documented. Nurses will document on Treatment Administration Records (TARs) that access site has been assessed. Charts of current residents with physician's orders for fluid restriction will be reviewed for compliance and appropriate documentation. Physician will be notified of non-compliance.Medication observation audits will be conducted on residents receiving medication that requires a pulse	01/20/2013

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	vein) dialysis access site. A. The dialysis care plan, dated 12/05/12, indicated the staff were to monitor for complications following dialysis, monitor fluid restrictions as ordered, and to monitor vascular access site for color, warmth, redness, drainage, bleeding, and dressing. The Nurses' Notes and Medication/Treatment Administration Records, dated 11/12 and 12/12, lacked documentation the resident's vascular access site, and condition had been been assessed prior to or upon return of the resident from dialysis. During an interview on 12/17/12 at 8:45 a.m., LPN #11 indicated the facility communicated with the dialysis center over the phone or they will send a fax if there is new orders. She indicated there were no assessments completed by the staff before or after the resident goes to dialysis. She indicated she makes sure the resident's dressing in intact on the access site. She indicated if the staff were assessing the access site, it would be documented on the Medication Administration Record, then indicated the access site had not		prior to administration by Director of Health Services (DHS) to ensure compliance.Residents receiving prn pain medications will have Medication Adminstration Records (MAR)s reviewed for use or prn pain medications. After review of MARs, DHS or designee will determine if a Pain Assessment and Circumstance Form will be initiated for 72 hours monitoring of pain for each resident. Physician will be notified as necessary.3. Nurses will be in-serviced on Guidelines for Dialysis Provider Communication. Nursing staff will be in-serviced on policy for Guidelines for Fluid Restriction. Nurse will document any non-compliance related to physician orders and notify physician. Nursing staff will be in-serviced on following orders as indicated related to taking pulse prior to medication administration as indicated.Nursing staff will be in-serviced on Guidelines for Pain Assessment and Management.4. Director of Health Services (DHS) or designee will review TARs of residents receiving dialysis services 3x's/week x 1 month, then weekly x 5 months.DHS or designee will review fluid consumption for each resident with physician's orders for fluid restriction 5x's/week x 2 weeks, 3 x's/week for 2 weeks, weekly x 2 months, then monthly x 3 months to ensure compliance.Medication pass audits will be conducted by	

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	been assessed. She indicated the dialysis center does not send a report back to the facility with the resident. An undated facility policy, received as current from the Nurse Consultant on 12/17/12 at 10:55 a.m., titled, "Guidelines For Dialysis Provider Communication", indicated, "...A report...shall be requested from the Dialysis Provider that will alert campus regarding:...other information deemed necessary for ongoing provision of care. 5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication b. Review the Dialysis Provider paperwork for any necessary follow up requirements..." An undated policy from the Dialysis Center, received from the MDS LPN on 12/17/12 at 11:50 a.m., titled, "Hemodialysis Catheter: Exit Site Care...", indicated, "...To establish guidelines for catheter exit site care to reduce the infectious complications associated with intravascular catheter use...dressing changed after each Hemodialysis treatment and/or if dressing becomes damp, soiled or non-adhering or when inspection of the site is necessary...Early identification/treatment of exit site		DHS or designee weekly on each shift x 1 month, then monthly on each shift x 5 months.DHS or designee will audit residents receiving prn medications 3 x's/week x 1 month, then weekly x 5 months to ensure compliance with pain management guidelines.Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	changes/inflammation minimizes infectious complications and preserves catheter integrity/function..." B. A physician's order, dated 12/07/12, indicated to limit the resident's fluids to one liter (1000 cubic centimeters) (cc) per day. The Physician's Recapitulation Orders, dated 12/12, indicated the resident received one bottle of Boost (dietary supplement) (237 cc) daily on day shift. The resident's fluid intake record the following daily intakes: 12/08/12-1440 cc 12/09/12-1710 cc 12/10/12-1380 cc 12/11/12-1120 cc 12/12/12-1140 cc 12/13/12-1230 cc 12/14/12-900 cc 12/15/12-1660 cc 12/16/12-1224 cc During an interview on 12/17/12 at 8:45 a.m., LPN #11 indicated the resident received 90 cc of fluid with each medication pass. She indicated the resident did not get medications at noon so they give the resident 180 cc's of fluid with the morning			

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	medication pass. (360 cc/day with medication pass) During an interview on 12/17/12 at 9:29 a.m., the Dietary Manager (DM) indicated the resident received 213 cc's per meal. She indicated the Registered Dietician should implement a care plan on fluid restrictions. She indicated the nurse communicated the fluid restriction through a dietary order form and then she wrote the information on the resident's tray card. She indicated she was unaware the resident received Boost daily. She indicated she thought the Boost had already been included into the nurses' fluids. She indicated the Registered Dietician (RD) checks the residents weekly. She indicated the last time the Registered Dietician had assessed the resident was on 11/29/12. During an interview on 12/17/12 at 10:10 a.m. the DM indicated the RD was not informed of the fluid restriction. 2. During an observation on 12/14/12 at 7:38 a.m. LPN #4 prepared Resident #56's medications, which included Lanoxin (heart medications) 250 micrograms.			

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LPN #4 then entered the resident's room and obtained the resident's radial pulse for 15 seconds and stated it was, "16". (64/min), and administered the medications.

The resident's Physician's Recapitulation Orders, dated 12/12, indicated and order for Lanoxin 250 micrograms, one tablet daily for atrial fibrillation and to hold the medication if the resident's heart rate was less than 50.

During an interview on 12/17/12 at 2:52 p.m., the Nursing Consultant indicated the facility did not have a policy on administration of Lanoxin.

A facility Professional Resource, titled, "Nursing Drug Handbook 2012", indicated, "digoxin (Lanoxin)...ADMINISTRATION...Before giving drug, take apical-radial pulse for 1 minute..."

3. Resident #12's clinical record was reviewed on 12/17/12 at 11:00 a.m. Resident #12's diagnoses included but were not limited to, arteriosclerosis, chronic right leg pain, COPD (chronic obstructive pulmonary disease/lungs), PVD (peripheral vascular disease), CVA (cerebral

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	vascular accident/stroke) with hemiplegia (paralysis), and a vertebral compression fracture. A care plan initiated on 5/16/12 and updated on 8/14/12 indicated the resident had acute and chronic pain AEB (as evidenced by) complaints of pain. The interventions indicated to monitor and report to nurse signs and symptoms of pain, worsening pain, report changes in pain location/type frequency/intensity to physician, provide comfort measures, relaxation techniques, repositioning, administer medications, monitor effect and for side effects from routine pain medications/prn (as needed) pain medications, invite, encourage, remind and escort to preferred activities, consultation as needed, educate resident/family about comfort measures, analgesic medications, notify the resident physician if the resident does not state/demonstrate relief or reduction of pain after one hour or receiving the first intervention,and make a referral to resident's physician to consider premedication for pain prior to activity to optimize participation. A Pain Circumstance, Assessment, Data Collection and Intervention form dated 9/18/12 at 00:20 a.m. (12 a.m.)			

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	indicated the resident had generalized pain related to osteoarthritis, vertebral compression fracture, and chronic right leg pain. The intensity indicated severe pain and the resident experienced pain almost constantly in the last 5 days. The assessment indicated the pain limits the residents activities, sleep and sitting. Factors contributing to pain was therapy and turning in the bed. Symptoms/behaviors related to pain was anger and combativeness. The assessment stopped on 9/21/12 10:00 p.m. to 6:00 a.m. shift. A care plan initiated on 6/19/12 for behavior problems, interventions on 7/18/12 indicated to ask the resident if he was in pain and respond appropriately. A quarterly MDS (Minimum Data Set) Assessment dated 9/14/12 indicated the resident was cognitively intact. An IDT (Interdisciplinary Team) note dated 9/21/12 indicated they felt the residents behavior of yelling out was related to pain. A CAR (Care Area Review) note dated 9/26/12 indicated the resident had verbal and physical behaviors but staff indicated he was "getting a little			

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	better". 9/26/12 Resident First Conference Notes indicated no pain issues. A Social Service note dated 10/2/12 indicated the resident became verbal and physical aggressive during ADL care at 2:00 a.m. due to being awakened. Nursing requesting physician for an order of an antidepressant or anti-anxiety medication routinely. The 10/2012, 11/2012, and 12/2012 Physician Recapitulation Orders indicated the resident was started on Fentanyl 50 mcg/hr (microgram per hour) (narcotic) patch for chronic pain on 9/17/12. Tylenol 650 mg three times a day was started on 10/3/12. It also indicated hydrocodone (pain medication) 5/325 mg (milligrams) every four hours as needed, acetaminophen 650 mg every four hours as needed for pain was started on 10/3/12. A physician's note dated on 10/3/12 indicated the resident complained of pain and had increased Fentanyl patch to 50 mcg. A Nurse Practitioner's note dated on 10/17/12 did not indicate a follow up			

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	of pain. The October Monthly Nursing Assessment did not indicate an assessment of the pain section. The PRN (as needed) MAR (Medication Administration Record) sheet indicated hydrocodone was given on 11/7/12 at 11:50 p.m., 11/8/12 at 4:40 p.m., 11/11/12 at 12:05 p.m., 11/16/12 at 5:25 p.m., 11/17/12 at 6:35 p.m., 11/20/12 "x 1", 11/22/12 "x 1", 11/28/12 "x 2", 11/29/12 "x 1". The narcotic sheet indicated the resident received 15 doses of hydrocodone versus the 10 indicated on the medication record. The PRN MAR sheet indicated hydrocodone was given on 12/3/12 at 2:15 a.m., 12/4/12 at 2:45 a.m., 12/7/12 with no specific time, 12/8/12 at 3:45 a.m., 12/10/12 at 3:45 a.m., 12/12/12 with no specific time, 12/13/12 "x 2". The PRN medication tracking sheet indicated hydrocodone was given on 12/4/12 at 2:45 a.m., 12/5/12 at 2:10 p.m., 12/6/12 at 4:45 p.m., 12/7/12 with no specific time, 12/8/12 at 3:45 p.m., 12/10/12 at 3:45 a.m., 12/13/12 at 1:30 a.m., and 12/13/12 at 5:20 a.m.			

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	155782	A. BUILDING 00 B. WING	12/21/2012

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The narcotic sheet between 12/1/12 to 12/10/12 indicated the resident received 9 doses of hydrocodone versus the 5 doses indicated on the medication record and the 6 doses indicated on the PRN medication tracking sheet.

A Monthly Nursing Assessment dated 11/8/12 indicated in the last 5 days, the resident received prn pain medications and scheduled pain regimen. The assessment indicated pain was frequent and he had moderate pain with facial grimacing. The pain had limited daily activities. The resident had vocalized complaints pain to his back, "legs, all over". There was no assessment done for the month of December.

A Nursing Note indicated on 11/10/12 at 12:30 p.m., the resident hit staff during care. The nurse spoke to the resident and he had indicated the staff "hurt him when they roll him over and clean him up."

A Nursing Note indicated on 11/17/12 at 2:00 p.m., the resident's left 5th toe was swollen, purulent drainage noted under the skin. The foot was red interiorly, and the resident complained of pain. The narcotic

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	sheet was observed and no vicodin was given for the resident's pain at this time. The scheduled 650 mg of Tylenol was observed on the MAR as given at 3:00 p.m. A physician note dated on 12/5/12 did not indicate a follow up of pain. An interview with the resident on 12/11/12 at 3:30 p.m., indicated he "hurts all over all the time and just wants to stay in bed and be left alone". An observation on 12/13/12 at 9:00 a.m. in the dining room, the resident complained of discomfort in his wheel chair to RA (restorative aide) #6. The resident was insisting he was sitting on a shoe but a CNA (certified nursing assistant) indicated to the resident she had put his shoes in his closet and he was sitting on a gel cushion. The resident indicated he was sitting on something hard. The resident was not checked or repositioned in his wheel chair. The SSD (Social Service Director) and ADON (Assisted Director of Nursing) on 12/18/12 at 10:00 a.m. The SSD indicated she was aware of the resident's pain and has been working with the staff. The SSD was			

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	not able to indicate how she was working with staff and indicated she receives her information from staff notes or behavior sheets. The ADON indicated there were pain assessment sheets the staff can fill out to document the resident's pain. The ADON was not aware of the staff not following up with the physician for the resident's continued pain despite the increase in the Fentanyl patch in September and was not aware the pain assessment had not been documented and pain scales were not used on the prn medication sheets. A Guideline for Pain Assessment and Management was provided by the Administrator on 12/18/12 at 3:00 p.m. The guidelines indicated "...Ongoing assessment will be documented on the Monthly Nursing Summary, and Skilled Nursing Assessment form if applicable...If there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care plan update...Assess for behaviors that may be indicators of pain or activities that increase indicators of pain. 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident's teeth were clean for 1 of 2 residents reviewed for ADL (activities of daily living) assistance. (Resident #56) Findings include: An interview with a family member on 12/12/2012 at 10:14 a.m., indicated Resident #56 does not receive the assistance she needs with routine oral hygiene. The family member indicated the staff was bad about the resident's teeth and hair. On 12/13/12 at 8:20 a.m., the resident was observed in the hallway near the unit lounge with her hair combed and was walking with restorative therapy to dining room for breakfast. Prior to eating breakfast, the resident's teeth were observed in conversation at the breakfast table, and were observed to have had a white substance in between her teeth near the gum line. Interview with the	F0312	1. Resident #56 had teeth cleaned during the time of the survey. No adverse affects were noted. 2. Residents requiring assistance with oral care have potential to be affected by this alleged deficient practice. Any residents that are identified in need of attention will be provided appropriate care. Any residents that require more assistance than is indicated on the Minimum Data Set (MDS) Assessment and/or care plan will have revisions made.3. Nursing staff will be in-serviced on providing adequate oral care. Director of Health Services (DHS) or designee will observe 100% of residents requiring assistance with oral care on various shifts 3 x's/week for 2 weeks, then 50% of residents requiring assistance with oral care weekly x 2 weeks, then random residents who require assistance with oral care weekly x 5 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committe x 6 months or until 100% compliance is achieved.	01/20/2013

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	Student Nurses' Aide during this time indicated she had cleaned the resident's teeth when she had gotten her up. Resident #56's record was reviewed on 12/13/12 at 8:45 a.m. Resident #56's diagnoses included but were not limited to, dementia, anemia, and cardiac dysrythmia's (irregular heart beat). The Quarterly MDS (Minimum Data Set) Assessment dated 10/1/12 indicated the resident was severely cognitively impaired and the resident received an assistance of 1-2 staff members for dressing and personal hygiene. A care plan initiated on 7/14/12 indicated the resident had an ADL (activities of daily living) self care deficit of dressing, toilet use, personal hygiene and bathing related to weakness. The interventions included, assess/record self care status changes, report significant changes in ADL status to physician and responsible party, assist with personal hygiene as needed including oral/dental care, assist of 1, and activities that promote hygiene and grooming			

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	On 12/13/12 at 10:00 a.m., Resident #56 observed to have a white substance in between her teeth and near the gum line. An interview with a family member on 12/13/12 at 2:30 p.m. indicated 6 denture tabs had been put in the resident's denture cup a few days ago and none of of the denture tabs had been used. On 12/13/12 at 3:15 p.m., 6 denture tabs was observed in the denture cup. 3.1-38(a)(3)(C) 3.1-38(b)(1)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a resident received appropriate assessments, treatment, and services to restore as much normal bladder function as possible, related to a resident who was continent of urine declined to frequently incontinent of urine for 1 of 1 resident reviewed for urinary incontinency. (Resident #35) Findings include: Resident #35's record was reviewed on 12/17/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to hypertension and dementia. The Admission Minimum Data Set (MDS) Assessment, dated 09/21/12, indicated the resident was continent of urine.	F0315	1. Resident #35 has had no adverse affects related to alleged deficient practice.2. Residents with changes in urinary incontinence have the potential of being at risk of alleged deficient practice. Any residents who experienced a change in incontinence based on Minimum Data Set Assessments (MDS's)and feedback from nursing staff within the last 30 days will have documentation reviewed to ensure an assessment was completed. If an assessment is not documented, one will be completed. 3. Nursing staff including Minimum Data Set Assessment Coordinator (MDSC) will be in-serviced on necessary assessment documentation with changes in urinary incontinence. Certified Resident Caregiver Associates (CRCA's) will communicate increased episodes of incontinence to the nurse who will initiate an Elimination Circumstance Form. If necessary,	01/20/2013

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	A Significant Change MDS Assessment, dated 10/22/12, indicated the resident was frequently incontinent of urine. A care plan, dated 11/07/12, indicated the resident was incontinent of bowel and bladder. The goals indicated, "Be Free (sic) of skin breakdown related to incontinence and Be clean and dry" The interventions included, "Complete bowel and bladder assessment at admission, quarterly and PRN (as needed), Provide incontinence care after each episode of incontinence...Toilet before and after meals, upon rising in the AM and before bed at night..." There was a lack of documentation to indicate an assessment had been completed with the Significant Change MDS Assessment to indicate the reason for the incontinency, type of incontinency, patterns of incontinency, and for a personal toileting schedule to prevent incontinency. During an interview on 12/17/12 at 11:50 a.m., the MDS LPN indicated a Significant Change MDS Assessment had been completed because the resident had a fall and had declined		a 72 hour Elimination Record/Schedule will also be inititated to determine patterns of incontinency and if a toileting schedule will prevent incontinency.4. DHS or designee will ensure any residents experiencing changes in urinary incontinence have an Elimination Circumstance Form completed with each change identified. This will be done 5 x's/week x 1 month, then 3x's/week x 1 month, then weekly x 4months. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	and that was when the incontinency started. 3.1-41(a)(2)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure medications were not left on top of the medication cart for 1 of 11 residents observed for medication administration, failed to ensure staff did not leave 1 of 3 units unattended, and failed ensure consistent monitoring of water temperatures for 3 of 3 units. (200 Unit, Residents #25, #28, #29, #55 #57, #67, and #97, LPN #4, RN #13, and CNA #14) B. Based on observation, interview and record review, the facility failed to ensure a tab alarm was secured as outlined manufacturing instructions, and failed to ensure a resident was transferred safely as ordered for 2 residents reviewed for accidents and supervision. (Resident #13 and #46) Findings include: A1. On 12/14/12, Resident #57's call light was observed to have been going off from 8:30 a.m. to 8:42 a.m.	F0323	1. Residents #29, #28, #29, #55, #57, #67 and #97 had no adverse affects noted related to alleged deficient practice. Resident #1 had no adverse affects noted related to alleged deficient practice. There were no adverse affects noted related to alleged deficient practice regarding water temperatures. Resident #13 had no adverse affects noted to alleged deficient practice. Resident #46 has had care plan interventions updated to reflect a 2 person transfer.2.Residents with alarms have potential to be at risk for alleged deficient practice. Nurses will be in-serviced to remain on unit when all Certified Resident Caregiver Assistants (CRCAs) go off unit.Residents receiving medications have potential to be at risk for alleged deficient practice. Licensed Nurses will be in-serviced on not leaving medications on top of the medication cart. A new mixing valve was installed on 1/8/13 to ensure consistent water temperatures within the acceptable range. Director of Plant Operations (DPO) now takes temperatures on every unit	01/20/2013

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	Resident #67's call light was observed to be going off from 8:32 a.m. to 8:39 a.m. Resident #67 was yelling out "oh" several times for assistance. There was no staff observed in the hallway from 8:32 to 8:39 a.m. Residents #25, #28, #29, #55, #57, #67, and #97 were left unattended on the floor. CNA #14 had walked a resident to the dining room and the LPN #4 was in the dining room passing medications. At 8:40 a.m., Resident #57 was observed walking back to her chair next to her bed and had indicated she went to the bathroom by herself. Interview with the CNA #14 on 12/14/12 at 8:50 a.m. indicated a CNA should have stayed on the unit during the meal time. Resident #67's clinical record was reviewed on 12/13/12 at 2:49 p.m. Resident #67's diagnoses included but were not limited to, atrial fibrillation (irregular heart beat), hypertension, COPD, and dementia. Resident #67's Monthly Nursing		5 x's/week. Nursing staff will be in-serviced on appropriate placement of the call lights within resident reach and compliance with bed alarms being secured and in use as indicated. Licensed nurses and Qualified Medication Aides (QMAs) will be in-serviced to document on the Medication Administration Records (MARs) when batteries are changed on alarms as indicated. Positioning and functioning of alarms will be added to MARs of those residents who have alarms for licensed nurses and/or QMAs to check and document every shift. Nursing staff will be informed of requirement of 2 person transfer for Resident #46.3. Director of Health Services (DHS) or designee will conduct random rounds on units on various shifts to ensure staff is present when resident(s) with alarms are present on the unit 5x's/week x 1 month, 3x's/week x 1 month, then weekly x 4 months. DHS will conduct random rounds on various shifts on various units to ensure medications are not left on top of the medication carts 5x's/week x 1 month, 3x's/week x 1 month, then weekly x 4 months. Executive Director or designee will review water temperatures 5x's/ week x 6 months to ensure water temperatures are at appropriate temperature and temperatures are being taken on every unit.Director of Health	

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	Assessment dated 11/9/12, the safety section indicated the resident has cognitive impairment that effects safety/judgment, had a history of falls, requires assistance for transfers and was non compliant with safety measures. Resident #57's clinical record was reviewed on 12/17/12 AT 2:00 p.m. Resident #57's diagnoses included but were not limited to Parkinson's Disease, CAD (coronary artery disease), anemia and arthritis. A care plan dated 9/18/12 indicated the resident had a fracture related to a fall. A care plan dated 9/18/12 indicated the resident had an impaired central nervous system related to Parkinson's Disease. A daily report sheet received from the Assistant Director of Nursing on 12/14/12 at 10:15 a.m. indicated 3 of the 7 residents left unsupervised on the floor had alarms related to having a history of falls or identified as a fall risk (Residents #29, #67, and #97. A2. During an observation on 12/13/12 at 7:47 a.m., RN #13 prepared Resident #1's medication, which consisted of Allopurinol (gout medication), aspirin, lexapro		Services or designee will conduct random rounds to ensure call lights are within reach and alarms are in proper place and functioning 5 x's/week x 1 month, 3x's/week x 1 month, then weekly x 4 months. Medical Records or designee will audit MARs to ensure licensed staff compliance with positioning, functioning and battery replacement of alarms 5 x's/week x 1 month, then 3x's/week x 1 month, then weekly x 4 months. DHS or designee will conduct random rounds during transfers of Resident #46 to ensure staff is compliant with 2 person transfers 3x/'s week x 1 month, then weekly x 5 months. 4.Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	(antidepressant), Metoprolol (blood pressure), Namenda (dementia), and Risperidone (antipsychotic). RN #13 then crushed the medications and placed them in a plastic medication cup. RN #13 then measured out a cap full of Miralax (laxative) and mixed the Miralax with a half glass of water. RN #13 then walked from the cart,which was in the hall outside of Resident #1's room, walked into the resident's bathroom to wash her hands, leaving the medications on top of the medication cart. The medication cart was not in view of RN #13. A3. During an observation with the Maintenance Director, on 12/13/12 at 4:24 p.m., the temperature of the sink in the public bathroom, also used by the residents of the facility, was 122.7. At 4:32 p.m. the water temperature in resident room 306 was 122.7. During an interview at the time of the observation the Maintenance Director indicated he was unsure when the facilities thermometer had been calibrated. He indicated he took water temperatures every morning.			

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A Plant Operational Overview, received from the Administrator on 12/14/12 at 11:45 a.m., indicated the Maintenance Director had a daily check list, which included water temperature checks in the residents' rooms.

The Daily Temperature Logs, dated 11/12 and 12/12, indicated only one room was checked daily for water temperatures. The form indicated the room checked was either a resident room, the Cafe', a shower room, a staff room, or an area in the facility's Assisted Living Unit.

During an interview on 12/14/12 at 11:45 a.m., the Administrator indicated there was not a policy for checking the water temperatures. She indicated the Plant Operational Overview did not state how many rooms the Maintenance Director should check.

B1. On 12/13/12 at 8:50 a.m., Resident #13 was observed in the dining room with her fall monitor not clipped to her body. CNA #5 was observed placing the clip onto the resident.

On 12/13/12 at 10:00 a.m., Resident

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	155782	A. BUILDING 00 B. WING	12/21/2012

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	#13 was observed in bed with no alarm observed on the bed. The call light was observed to be caught between the bed rail and the table hanging down near the floor. The DON was brought back into the room at 10:25 a.m., where a pull tab alarm was observed lying on the bed unsecured and clipped onto resident shirt. The call light was still out of the resident's grasp. Interview with the DON during the time indicated "it depends" when the alarm should be secured to the bed. The DON was observed to be looking around the bed for bed pad alarm, and did not notice the call light until it was brought to her attention. The DON moved tab alarm further away from resident, near corner of bed, and indicated these alarms were easy to trigger. Resident #13's clinical record was reviewed on 12/13/12 at 10:16 a.m. Resident's #13's diagnoses included but were not limited to, dementia with behaviors, hypertension, and chronic renal insufficiency. The Physician Recapitulation orders for 12/2012 indicated that on 6/12/12, a tab monitor was to be placed while the resident was in wheel chair and while in bed. Staff was to check positioning and functioning of monitor			

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	every shift. Staff was also to change the batteries to the alarms every month. The November and December MARs (Medication Administration Record) did not indicate if the batteries were changed and there was incomplete documentation for all shifts for checking tab alarm. A care plans was initiated on 6/25/12 and updated on 9/23/12 for the resident had a history of falls. The interventions indicated to "...call light w/in reach...6/12/12 [sic] tab alarm to wheel chair and bed and on 11/17/12, staff was educated on the alarm. An interview with LPN #9 on 12/12/2012 11:44 a.m. indicated the resident had fallen within the last 30 days but was unsure if there was any injuries. A manufacturing recommendation brochure was provided by the DON on 11/13/12 at 4:00 p.m. The recommendations indicated to "...attach the Attendant to a wheelchair, chair or bed using the strap or optional Universal Mounting Bracket, attach the alligator clip to the resident's garment...This product is not designed to operate with patient's...and should not be used as			

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	a bed fall monitor without the appropriate accessories...This product is not designed to replace good care giving practices including, but not limited to: direct patient supervision, adequate training of staff personnel for elopement, testing of the system before each use..." B2. During a clinical record review on 12/14/12 at 10:14 A.M., the Nurses' Note dated 12/9/12, indicated Resident #46 was guided to the floor by a CNA when transferring because, "the resident tried to sit too early." A care plan for falls,dated 6/20/12 indicated a revision on 9/10/12 adding the intervention to," transfer with lift or 2 person ", due to a fall. Another intervention was added and care plan revised on 12/9/12 to include, "encourage resident to use lift on transfer." A behavior care plan, dated 6/13/12, indicated Resident #46 should have 2 staff in the room while providing ADL's (Activities of Daily Living) due to behaviors such as physical abuse, verbal abuse, and sexually inappropriate remarks. The "Fall Circumstance Assessment and Intervention" investigation form, dated 12-9-12, indicated Resident #46 was attended by one CNA while waiting for a second CNA			

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	to assist with the transfer to the wheelchair but, "resident didn't want to wait." On 12/14/12 at 3:05 P.M., RN #9 was interviewed and indicated during the 12/9/12 fall, Resident #46 was being assisted by two staff members in the restroom until one left to retrieve a garbage bag. RN #9 indicated Resident #46 did not want to wait for the second staff to return to transfer to his wheelchair which led to the fall incident. RN #9 stated it wasn't uncommon for Resident #46 to be left with one staff if he wasn't ready to transfer. When asked whether RN #9 indicated she was aware the care plan indicated the resident required two staff to transfer. RN #9 stated the fall would have been potentially avoidable had the required 2 staff members been in attendance with Resident #46. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to implement approaches to ensure a resident maintained a usual body weight in 1 of 6 residents reviewed for weight loss and no dietary supplements. (Resident #67) Findings include: 1. Resident #67's clinical record was reviewed on 12/13/12 at 2:49 p.m. Resident #67's diagnoses included but were not limited to, atrial fibrillation (irregular heart beat), hypertension, COPD, and dementia. A care plan was initiated on 12/22/11 and reviewed on 09/13/12, indicated the resident was a nutrition risk. The interventions indicated to monitor and report to the physician signs and symptoms of malnutrition, significant weight loss, chewing/swallowing	F0325	1. Resident #67 no longer resides at the facility.2. Residents identified at risk for weight loss have the potential to be at risk of alleged deficient practice. Current residents identified at risk for weight loss will be reviewed for appropriate approaches for ensuring a usual body weight is maintained, interventions are added accordingly and Registered Dietician (RD) is notified of weight loss per facility guidelines.3. Assistant Director of Health Services (ADHS) is responsible for weight tracking and will be in-serviced on High Risk Nutrition Guidelines and Guidelines for Weight Tracking. These guidelines include documentation guidelines and when to communicate with the RD.4. Director of Health Services (DHS) or designee will audit residents with weight loss weekly x 6 months per Guidelines to ensure RD has been notified and that approaches and interventions have been initiated accordingly.	01/20/2013

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	problems; administer nutritional support as ordered (vitamin supplements), provide/monitor intake of diet/fluids; weigh and monitor results monthly and prn. A Nutrition Assessment and Data Collection was completed on 6/15/12. The assessment indicated the resident's usual body weight was 132 to 134 pounds and her BMI (Basal Metabolic Index) at that time was 21.2 which was slightly under the recommended 22. Resident #67's BMI had dropped to 19.9 on 12/2/12. On 6/21/12, the IDT (Interdisciplinary Team) Nutrition/Hydration Plan of Care was initiated on AEB (as evidenced by) decreased skin integrity. The target goal date was 9/21/12. The interventions indicated to give diet as ordered by the physician, honor resident preferences, offer snacks prn, monitor skin integrity via supportive documentation; medications as ordered by the physician, monitor weight for changes every month and prn, consult RD (Registered Dietician) prn, and review in CAR (Care Area Review) prn. A Dietary progress note on 9/13/12 indicated the resident's weight was		Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	128.8, been stable at 130+/- few pounds. There was no significant change in weight. The resident ate an average of 92.3% at meals and 100% bedtime snack. The resident received cottage cheese or yogurt three times a day between and with meals. The yogurt and the cottage cheese was discontinued due to a wound had healed. The labs from 9/10/12 reviewed. The Plan of Care was updated. There were no new interventions and to follow protocol as needed. A Hepatic Function blood test was done on 12/10/12 which indicated the resident's Albumin was 3.1 L (3.5-5.0). (Low can be an indicator for malnutrition) The resident's weight for the last 6 months are as follows: 6/15/12: 124.4 6/19/12: 131.6 7/6/12: 130.2 8/6/12: 133.0 9/8/12: 128.8 10/5/12: 130.8 11/6/12: 127.4 12/2/12: 123.0 A fax dated 12/11/12, to the physician, indicated the resident had lost 5% of weight in the past two			

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	months but "had gained since admission and was currently back to admission weight". An intake record dated 10/14/12 to 12/12/12, indicated the resident had ate less than 75% of 44 meals between breakfast, lunch, and dinner and 13 meals that were not indicated if the resident ate the meal or refused the meal. There were 45 days that a snack was not indicated if given or accepted and eaten. An interview with the DM (Dietary Manager) on 12/18/12 at 9:00 a.m., indicated she does not manage the clinical side of residents and the Dietician manages the weight losses and nutritional recommendations. An interview with the ADON on 12/18/12 at 10:30 a.m., indicated the DM does not manage the residents clinically when there was a weight loss. The ADON indicated she had notified the physician, family, and dietary about the weight loss and there were no new orders. The ADON indicated the Dietician had not been in the building this week to document. An interview with the Administrator and DON on 12/19/12 at 4:40 p.m.,			

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	indicated the ADON was responsible for monitoring weights and the procedure for notification was to document findings in a book/binder for the dietician to review, if she would recommend a supplement, the physician and family would be notified of the recommendation. The Dietician only visits the facility once a week. There was no system in place for following up and making sure the Dietician was aware of the weight losses. The Administrator indicated the physician should have been aware of the resident's usual body weight and reminded of abnormal labs when time passes and the abnormal lab may correlate with a change in condition. There has been no documentation by staff indicating if the dietician was informed of the weight loss and there has been no documentation/assessment by the Dietician indicating the weight loss. 3.1-46(a)(1)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to assess the resident for self administration of the nebulizer machine for 1 of 1 residents reviewed for self medication administration. (Resident #67) Findings include: 1. Resident #67's clinical record was reviewed on 12/13/12 at 2:49 p.m. Resident #67's diagnoses included but were not limited to, atrial fibrillation (irregular heart beat), hypertension, COPD, and dementia. On 12/13/12 at 4:00 p.m., LPN #3 was observed initiating Resident #67's nebulizer (breathing)treatment and left the room while the machine was running and the breathing treatment mask was on the resident's face. LPN #3 returned to give	F0328	1.Resident #67 no longer resides at facility.2.Residents receiving respiratory medications have potential to be at risk of alleged deficient practice. Incorrect policy wsa provided to state survey team during the time of the survey. Residents receiving respiratory medications will be assessed for self medication administration. Any changes will be documented and implemented accordingly.3. Licensed nurses will be in-serviced on the Respiratory/Inhalation Treament Guidelines which is the current policy the facility follows. It indicates that "if a resident is stable receiving the treatment the nurse does not need to remain in the room during the entire administration of treatment". Director of Health Services (DHS) or designee will conduct respiratory treatment observations on various shifts 3 x's/week x 1 month, weekly x 1 month and monthly x 4 months.4. Audit results will be brought to	01/20/2013

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	medication and left the room again. LPN #3 went into two other resident's room for assessment and medication administration before returning to Resident 67's room and indicated to her "5 more minutes" and she will be back. LPN #3 had not assessed the resident during the nebulizer treatment. On 12/14/12 at 9:49 a.m., LPN #4 was observed initiating Resident #67's nebulizer treatment and left room while machine was running. At 9:54 a.m., Resident #67 was observed to be coughing hard while the breathing treatment mask was on the face. LPN #4 was observed returning to the room after 10:00 a.m. before turning off the nebulizer machine. LPN #4 had not assessed the resident during the nebulizer treatment. A Specific Medication Administration Procedures policy dated 2/1/10 was provided by the Consultant on 12/14/12 at 10:50 a.m. The Consultant indicated this was the only policy she could find regarding nebulizer's. The policy indicated		monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	"...Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer, approximately five minutes after treatment begins (or sooner if clinical judgement indicates) obtain the resident's pulse, monitor for medication side effects, including rapid pulse, restlessness and nervousness throughout the treatment. 3.1-47(a)(6)			

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F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure that it was free of a medication error rate of 5% or greater, related to 3 medication errors out of 50 opportunities for error, resulting in a 6% error rate. This affected 2 of 11 residents observed for medication pass. (Residents #1 and #25) Findings include: 1. During a medication pass observation on 12/13/12 at 7:47 a.m., RN #13 prepared Resident #1's morning medication, which included Miralax Powder (laxative) 17 grams (one lid full). RN #13 poured a capful of the Miralax into a small cup and mixed it with 1/2 glass of water. RN #13 then entered the resident's room and administered the medications. During an interview directly after the administration of the medications, RN #13 indicated the glass with the Miralax held 120 cc's (cubic	F0332	1. For Residents #1and #25, nurse will be re-educated on alleged deficient practice related to medication errors. No adverse affects were noted.2. Residents receiving medications from nursing staff have potential of being at risk of alleged deficient practice. Medication times will be reviewed to ensure compliance with those requiring specific times per pharmacy recommendations. Medication carts will be audited to ensure appropriate cups are available in order to accomodate the amount of liquid as written per the order.3. Nurses and Qualified Medication Aides (QMAs) will be in-serviced on following physician's orders and providing medications at correct delivery times as indicated. Nurses and QMAs will have medication observations conducted throughout their employment no less than annually and as needed. Medication pass audits will be conducted by Director of Health Services (DHS) or designee weekly on each shift x 1 month, then monthly each shift x 5 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until	01/20/2013

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	centimeters) (4 ounces). She indicated she gave four ounces of water with the Miralax. She indicated she should have used an eight ounce cup. Review of the resident's Physician's Recapitulation Orders, dated 12/12, on 12/13/12 at 10 a.m., the orders indicated, to give Miralax powder 17 grams in eight ounces of liquid. 2. During an observation on 12/13/12 at 7:59 a.m., RN #13 prepared Resident #25's medication. RN #13 placed the following medications in plastic medication cup: Macrobid (antibiotic) 100 mg (milligrams) omeprazole (stomach medication) 20 mg multivitamin Oyst-Cal 500+D 200 IU aspirin 81 mg ferrous sulfate (iron) 325 mg hydrocodone 5/325 mg (pain medicine) Prozac (antidepressant) 10 mg RN #13 then administered the resident's medications to the resident. During an interview after the medications had been given, RN #13 indicated the resident had just come back to her room from eating		100% compliance is achieved.	

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	breakfast. She indicated she was finished with the resident's morning medications. The resident's Physician's Recapitulation Orders, dated 12/12, were reviewed on 12/13/12 at 8:30 a.m. The orders indicated an order for Methenamine Hippurate (reduces the development of drug-resistant bacteria) 1 gm (gram) before meals. During an interview at the time of the review, RN #13 indicated she had not given the Methenamine. A facility Professional Resource, titled, "Nursing Drug Handbook 2012", indicated, "omeprazole...Give at least 1 hour before meals..." A facility policy, dated 2/10, titled, "Medication Administration-General Guidelines", received as current from the Nurse Consultant, indicated, "...Medications are administered in accordance with written orders of the attending physician...Medications are administered either 60 minutes before or after the scheduled time, except before or after meal orders, which are administered (based on mealtimes)..." 3.1-25(b)(9) 3.1-48(c)(1)			

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	3.1-48(c)(2)			

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F0361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. Based on record review and interview, the facility failed to ensure the Dietary Manager (DM) worked with the Registered Dietician (RD) to ensure the facility met the nutritional needs of each resident, related to a fluid restriction for 1 of 2 residents reviewed for fluid restriction. (Resident #95) Findings include: Resident #95's record was reviewed on 12/17/12 at 8:28 a.m. The resident's diagnoses included, but were not limited to, renal dialysis and kidney disease.	F0361	1. Resident #95 no longer resides at the facility.2. Residents with physician's orders for fluid restriction have potential of being at risk of alleged deficient practice. Charts of current residents with physician's orders for fluid restriction will be approved for compliance and appropriate documentation.3. The Director of Food Services (DFS) will be in-serviced on working with the Registered Dietician (RD) to ensure the facility meets the nutritional needs of the residents according to the DFS job description.4. DHS or designee will review fluid consumption for each resident with physician's orders for fluid restriction 5x's/week x 2 weeks, 3x's/week for 2 weeks, weekly x 2	01/20/2013

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	A physician's order, dated 12/07/12, indicated to limit the resident's fluids to one liter (1000 cubic centimeters) (cc) per day. The resident's fluid intake record the following daily intakes: 12/08/12-1440 cc 12/09/12-1710 cc 12/10/12-1380 cc 12/11/12-1120 cc 12/12/12-1140 cc 12/13/12-1230 cc 12/14/12-900 cc 12/15/12-1660 cc 12/16/12-1224 cc During an interview on 12/17/12 at 8:45 a.m., LPN #11 indicated the resident received 90 cc of fluid with each medication pass. She indicated the resident did not get medications at noon so they give the resident 180 cc's of fluid with the morning medication pass. (360 cc/day with medication pass) During an interview on 12/17/12 at 9:29 a.m., the Dietary Manager (DM) indicated the resident received 213 cc's per meal. She indicated the Registered Dietician should implement a care plan on fluid restrictions. The DM indicated she does not write care plans or		months and monthly x 3 months to ensure compliance. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committe x 6 months or until 100% compliance is achieved.	

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	interventions on the care plan. She indicated she does not do they record assessments. She indicated the nurse communicated the fluid restriction through a dietary order form and then she wrote the information on the resident's tray card. She indicated she was unaware the resident received Boost daily. She indicated she thought the Boost had already been included into the nurses' fluids. She indicated the Registered Dietician (RD) checks the residents weekly. She indicated the last time the Registered Dietician had assessed the resident was on 11/29/12. During an interview on 12/17/12 at 10:10 a.m. the DM indicated the RD was not informed of the fluid restriction. The Director of Dining Services job description, dated 10/09, received as current from the DM on 12/18/12 at 8:45 a.m., indicated, "...Process diet changes and new diets as received from nursing services...Ensure that charted dietary progress notes are informative and descriptive of the services provided and the resident's response to the service...Assist in developing preliminary and comprehensive assessments of the			

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	dietary needs of each resident. Assist in developing a written dietary plan of care...that identifies the dietary problems/needs of the resident...Review and revise care plans and assessments as necessary..." 3.1-20(a)			

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F0441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review,	F0441	1. Residents #1, #3, #12, #13, #23, #24, #51, #55, #56, #48 and	01/20/2013

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	and interview, the facility failed to follow infection control guidelines, related to not washing hands in-between touching residents during a lunch meal service, which had the potential to affect 36 residents who were eating their meal in the dining, not washing hands after resident contact, not sanitizing equipment used for multiple residents after use, storing opened packages of briefs on the floor, soiled urine collection containers uncovered in the bathroom, and resident toothbrushes uncovered/unlabeled in the bathroom for 2 of 3 units (200 and 300), not having single use/assigned supplies for 1 of 2 isolation rooms (Residents #1, #3,#12, #13, #23, #24, #51, #55, #56, #48, and #67) (Dietary Manager (DM), LPN #3, LPN #4, CNA #5, CNA #8 Restorative Aide #6 Cook #10, and RN #13), and storing open and used skin protectant in the treatment carts without being separated (100, 200, and 300 unit). This had the potential to affect 55 of 55 residents residing in the facility. Findings include: 1. During an observation on 12/13/12 at 7:33 a.m., RN #13 obtained Resident #1's blood pressure with a digital wrist cuff and also obtained the		#67 had no adverse affects noted.2. Residents residing at this facility have potential to be at risk of alleged deficient practice. Staff in each department will be in-serviced on proper handwashing practices. Nursing staff will be in-serviced on proper cleaning techniques of equipment for multi-resident use, proper storage of items that belong to individual residents in resident rooms and in treatment carts and education to nursing staff related to dedicated equipment for residents in isolation.3. Director of Health Services (DHS) or designee will conduct rounds on units at various times to include checking resident bathrooms and treatment carts for proper storage of personal items, observation of proper handwashing practices during meals, during care, during medication pass, observation of proper cleaning of equipment used by multiple residents and those residents in isolation. Rounds will be conducted 5 x's /week x 1 month, then weekly x 5 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	

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	resident's oxygen saturation with the facility's oxemeter. RN #13 then left the resident's room and placed both the blood pressure cuff and oxemeter in a basket on top of the medication cart. RN #13 did not sanitize the items prior to placing the items in the basket. 2. During an observation on 12/14/12 at 10:03 a.m., LPN #4 listened to Resident #67's breath sounds and obtained the resident's oxygen saturations with the facility's oxemeter. The stethoscope was then placed around the back of LPN #4's neck, and LPN #4 then left the resident's room without washing her hands or sanitizing the oxemeter. LPN #4 then placed the oxemeter in a basket on top of the medication cart and began looking through her Medication Administration Records and pulled the medication cart down the hallway. During an interview on 12/14/12 at 10:06 a.m., LPN #4 indicated she washed her hands every three residents and use alcohol gel between residents. She indicated she had just touched the stethoscope, so that is why she did not wash her			

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	hands. She indicated she sanitizes her stethoscope with alcohol every morning. She indicated she was unsure what the policy was for sanitizing the stethoscope and oxemeter. She indicated she does not sanitize the stethoscope and oxemeter between residents. She indicated it would be a good idea if the items were washed between residents. She indicated if the resident was really sick she would wipe the oximeter finger probe with alcohol gel. An undated facility policy, titled, "Stethoscope Cleaning Guidelines", received as current from the Administrator on 12/14/12 at 11 a.m., indicated, "...To prevent cross contamination when using a stethoscope between residents and/or when a stethoscope is used by multiple staff members...Gather disposable alcohol wipes or a bottle of alcohol and cotton balls to clean the stethoscope...Using firm pressure, clean the stethoscope ear pieces, tubing, diaphragm and bell in a circular motion with alcohol wipe or alcohol socked (sic) cotton ball..." 3. On 12/13/12 at 4:00 p.m., LPN #3 was observed assessing Resident #67 with her own stethoscope and			

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	placed it back around her neck then applied a pulse oximeter probe around the resident's finger. LPN #3 left the room and placed the pulse oximeter machine back in basket with other equipment without being cleaned. LPN #3 had placed Resident #67 nebulizer machine on the floor while the resident was receiving treatment. LPN #3 left the room again and returned to Resident #67's room with an ear thermometer and took the resident's temperature in her ear. LPN #3 then disposed the cover in the bathroom and left the room without cleaning the thermometer and washing hands. LPN #3 came back into the room to ask the resident if she wanted Tylenol, returned back to medication cart, went back to the resident's room and asked her about her pain intensity, went back to the medication cart and returned to the resident's room to give the Tylenol and restarted the nebulizer. LPN #3 left the room without cleaning any equipment, her stethoscope, or washing her hands. LPN #3 then went to Resident #60's			

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	room and checked the resident's blood pressure with an electric, wrist monitor and put the monitor back in basket with other equipment on the medication cart without cleaning it. LPN#3 then prepared Resident #60's medication and took it to the resident. At this time, LPN #3 washed her hands. LPN #3 was then observed to return to her medication cart, go into Resident #13's room, then went back to Resident #67's room and returned to her medication cart. LPN #3 was then observed to remove a bag of trash on the side of the cart. LPN #3 had gone back to the medication cart, grabbed the pulse oximeter machine and placed it under her arm. LPN #3 returned to Resident #13's room, put the head of bed up, gave medication and put the head of the bed back down. She left the room without washing her hands and grabbed the pulse oximeter from under her arm and gone into Resident #67's room. LPN #3 then removed Resident #67's mask, placed it back into the bag and placed the nebulizer machine back on the table. The pulse oximeter was			

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	laid on the resident's chair while she assessed the resident's lung sound with her stethoscope again. LPN #3 put the stethoscope back around her neck without washing it. LPN #3 placed the pulse oximeter on the resident's bedside table, assisted the resident to the bathroom. LPN #3 did wash her hands but she brought the pulse oximeter back out to the medication cart and didn't clean it. 4. LPN #4 was observed on 12/14/12 at 9:54 a.m., to go into Resident #67's room and turned off the nebulizer machine. LPN #4 assessed the resident lungs with her stethoscope and walked out of room without washing hands or cleaning the stethoscope. The pulse oximeter was used on the resident and was placed back into the basket on the medication cart without being cleaned. An undated facility policy, titled, "Pulse Ox Cleaning Guidelines", received as current from the Director of Nursing (DoN) on 12/14/12 at 11 a.m., indicated, ""...To prevent cross contamination when using a Pulse ox between residents and/or when a stethoscope (sic) is used by multiple staff members...Gather disposable alcohol wipes or a bottle of alcohol			

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	and cotton balls to clean the Pulse ox...Using firm pressure, clean the Pulse ox, wires, probe in a circular motion with alcohol wipe or alcohol socked (sic) cotton ball..." 5. During an interview on 12/14/12 at 10:55 a.m., The DoN indicated the resident's in isolation have their own blood pressure cuff and equipment. She indicated they are either kept in the room or in the drawer in the isolation dresser. During an observation of Resident #48's room, with the Nurse Consultant present, there were no blood pressure cuff and stethoscope located in the room or in the isolation dresser. During an interview at the time of the observation, the Nurse Consultant indicated the resident had Clostridium Difficile (C-Diff). During an interview at the time of the observation, LPN #4 indicated she takes the blood pressure cuff into the room to get the resident's blood pressure. She indicated she had asked for a blood pressure cuff and stethoscope for the resident but they were never available for the resident. She indicated she cleaned her			

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	stethoscope with alcohol after she used it for the resident. She indicated she did not sanitize the blood pressure cuff. An undated policy, received from the DoN as current on 11/14/12 at 1:10 p.m., titled, "Contact Precautions", indicated, "...Contact Precautions are indicated to prevent and control nosocomial transmission of infection with any of the following:...Clostridium Difficile...Procedure...Dedicated equipment per resident or the cleaning of equipment between residents is required...A stethoscope, sphygmomanometer (blood pressure cuff)...thermometer should be dedicated to individual residents. If use of common equipment is unavoidable, then adequate cleaning and disinfecting is necessary before use with other residents..." 6. During an observation on 12/11/12 at 11:19 a.m. Resident #23's bathroom contained a toothbrush in a plastic cup with bristles uncovered sitting on the bathroom sink (shares bathroom with another resident). During an interview at the time of the observation the resident stated the toothbrush was hers. She stated there was no other place to keep			

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	them. During an observation on 12/17/12 at 1:25 p.m. with the Maintenance Director and the Director of Housekeeping, Resident #23's bathroom contained a toothbrush in a plastic cup with bristles uncovered sitting on the bathroom sink. 7. On 12/11/12 at 10:09 a.m., Resident #55 and #56's tooth brushes were observed in the bathroom, on a table, uncovered in a cup. A white measuring collection hat was observed behind the toilet on the floor, uncovered. On 12/13/12 at 9:21 a.m., Resident #55 and #56's tooth brushes were observed in the bathroom on a table, uncovered, next to the toilet. A package of incontinent briefs was observed on the floor opened, next to the toilet. A white measuring collection hat was observed behind the toilet on the floor, uncovered. On 11/14/12 at 11:00 a.m., Resident #55 and #56 toothbrushes was observed on in the bathroom on a table, uncovered, next to the toilet. A package of incontinent briefs was observed on the floor opened, next to the toilet, and a soiled washcloth			

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	observed on bathroom floor. 8. During an observation of the 200 Unit Treatment Cart on 12/17/12 at 2:43 p.m., with LPN #12 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. LPN #12 acknowledged the tubes were not stored in a sanitary manner. During an observation of the 100 Unit Treatment Cart on 12/17/12 at 3:03 p.m., with RN #14 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. RN #14 acknowledged the tubes were not stored in a sanitary manner. During an observation of the 300 Unit Treatment Cart on 12/17/12 at 3:07 p.m., with RN #15 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. RN #15 acknowledged the tubes were not stored in a sanitary manner. 9. During dining observation in the			

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	Main Dining Room, on 12/11/12 at 12:25 P.M.,Cook #10 was serving plates at the steam table without the use of gloves when she went into the kitchen by pushing the swinging door open with her bare left hand. Cook #10 returned and continued to serve food onto plates without washing her hands or without using the antibacterial gel which is mounted to the wall next to the kitchen door. Cook #10's bare thumbs were observed to be on the topside of each plate as she was serving the food. On 12/11/12 at 12:34 P.M., Cook #10 was again observed to leave the serving line to enter the kitchen pushing the door open with her bare hand. She returned to serving plates without washing her hands or using antibacterial gel. On 12/11/12 between 12:35 p.m. to 1:00 p.m., the DM (Dietary Manager) was observed to have touched a resident while placing a clothing protector on them and went to the steam table, picked up a tray of food and passed it out to the residents. The DON was observed coming into dining room and began passing out trays to residents in the smaller dining room and did not wash her hands/use hand sanitizer prior to passing out the			

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	tray of food. The DM was observed to have her hand on resting on the top of her head while holding a tray, walked to the fluid area, grabbed a glass, walks into the kitchen. The DM came out with milk in a glass and delivered it to a resident. The DM bends over speaking to a resident and touches her legs, grabs another glass off of the table, walked to the fluid area, fills the glass with juice and returns it to the resident. Again, she touches her legs, took a plate off of a table and took it to a counter, cuts up the food on the plate and returns it to the resident. The DM touches a resident's wheel chair, touches another resident and then washes her hands. On 12/11/12 at 12:44 P.M., the Dietary Manager (DM), who was assisting in delivering plates by tray, was observed going into the kitchen using her bare hands on the door. The DM came out of the kitchen holding individual serving size dishes in her hand. Without washing her hands or using antibacterial gels, the DM proceeded to serve plates with bare hands. On 12/11/12 at 12:49 P.M., the DM went into the kitchen, opened the door with her bare hands and			

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	returned with a glass of liquid. She proceeded to continue serving with no hand washing or gel. On 12/11/12 at 12:53 P.M., Cook #10 went into the kitchen using her bare hand on the door and came out with a stack of clean dishes. She proceeded to serve food onto plates without washing her hands or using gel. 10. On 12/13/12 at 8:45 a.m., RA #6 (Restorative Aide) was observed assisting a Resident #12 up in the wheelchair and then started to pass out a breakfast plate to Resident #51. RA #6 then repositioned Resident #1 in her wheel chair and began passing out another breakfast plate to 2 other residents. RA #6 then repositioned Resident #12's wheel chair under the table, put on clothing protector on the resident, then sat down between Resident #24 and #12. RA #6 began to assist Resident #24 with breakfast			

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	and turned around and wiped of Resident's #12 mouth. At this time did RA #6 got up and sanitized her hands. CNA #5 came into the small dining room and picked up a plate of food and delivered it to Resident #13 and began to assist her with her meal. CNA #5 wiped Resident #13's mouth off with a towel, clipped wheel chair alarm to the resident and began to assist Resident #1 by cutting up a cinnamon roll. CNA #5 returned to Resident #13 and wiped off her face and left to go to the kitchen to get another bowl of oatmeal for Resident #1. CNA #5 returned with a bowel of oatmeal, moved a chair from Resident #13's table to Resident #3 table and sat in between Resident #3 and #51. CNA #5 then got up and walked over to Resident #55 and cut up her cinnamon role. CNA #5 then started to cut Resident #51's cinnamon role. CNA #8 came into dining room, sanitized her hands, cut up a cinnamon role for Resident #56 then repositioned Resident #3, then removed dishes from Resident #12. CNA #8 sanitized her hands, removed Resident #51 clothing protector, removed the resident from			

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	the dining room. Resident #3 asked for a glass of milk and CNA #8 took the glass from the table and returned with milk. CNA #8 did not sanitize her hands. When CNA #8 did sanitize her hands, she removed a clothing protector from Resident #56, touched the residents wheel chair, then touched Resident #3 plate to encourage the resident to eat. RA #6 and CNA #8 were interviewed during this time. Both indicated hand washing or sanitizing should be done in between each resident contact. 3.1-18(l) 3.1-19(r)(1)(2)			

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview,the facility failed to provide a sanitary and comfortable environment for residents related to urine odors in resident rooms (Residents #58 and #64), Accumulation of dust on a dresser and TV (Resident #30), opened bag of briefs stored on bathroom floors (Residents #30, #55, and #56), and soiled urine collection containers stored in the bathroom (Residents #54, #55, and #56) during environmental observations for 2 of 3 units. Findings include: 1. During an observation on 12/11/12 at 11:17 a.m., there was an accumulation of dust on Resident #30's dresser and TV. There were three opened bags of briefs stored on the floor of the bathroom. During an observation on 12/17/12 at 1:25 p.m., with the Director of Housekeeping and the Maintenance Director present, there was an accumulation of dust on the resident's dresser and TV. There were two	F0465	1. Residents #58, #64, #30, #54, #55 and #56 had rooms and equipment cleaned at the time of survey to address alleged deficient practice. No adverse affects were noted. 2. Residents receiving care at this facility have potential to be at risk of alleged deficient practice. Rounds will be conducted by Director of Plant Operations (DPO) or designee to identify any resident rooms with urine odors, dust and/or opened bags of briefs stored on bathroom florrs and/or soiled urine collection containers stored in bathroom. DPO will provide results to Director of Environmental Services (DES).3. DES and environmental services staff will be in-serviced on providing sanitary and comfortable environment for residents. DES or designee will conduct rounds of resident rooms 5 x's/week x 1 month, 3 x's/week x 1 month, then weekly x 4 months on various units at various times to ensure compliance with odors, dust and proper storage of personal items in resident bathrooms.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or	01/20/2013

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	opened bags of briefs stored on the floor of the bathroom. During an interview at the time of the observation on 12/17/12, the Director of Housekeeping indicated the resident's rooms are dusted daily. 2. During an observation on 12/11/12 at 10:53 a.m., there was a strong odor of urine in Resident #58's bathroom. During an interview at the time of the observation, LPN #11 indicated the bathroom, "needs attention". 3. During an observation on 12/13/12 at 4:32 p.m. with the Director of Maintenance present, there was a strong odor of urine in the room and bathroom of Resident #64. During an observation on 12/17/12 at 9:18 a.m., there was a urine odor in Resident #64's bathroom. During an observation with the Director of Maintenance and the Housekeeping Director present on 12/17/12 at 1:25 p.m., there was a urine odor in resident #64's room and bathroom. During an interview at the time of the		until 100% compliance is achieved.	

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	observation, the Housekeeping Director indicated there was a soiled brief in the resident's trash can in the bathroom. She indicated the CNA's should have taken the soiled brief out of the room. 4. On 12/11/12 at 10:05 a.m., a white measuring collection hat with dried yellow substance was observed in a corner between the wall and the toilet, on the floor, uncovered in Resident #54's bathroom. On 12/11/12 at 10:09 a.m., a white measuring collection hat was observed behind the toilet on the floor, uncovered in Resident #55 and #56 room. On 12/13/12 at 9:21 a.m., a package of incontinent briefs was observed on the floor opened, next to the toilet. A white measuring collection hat was observed behind the toilet on the floor, uncovered in Resident #55 and #56 room. On 11/14/12 at 11:00 a.m., a package of incontinent briefs was observed on the floor opened, next to the toilet. 3.1-19(f)			

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F0520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview the failed to ensure the facility QAA (Quality Assessment and Assurance) committee identified system failure concerning infection control, which had the potential to affect 36 residents who eat in the Main Dining Room and the Residents who reside on 3 of 3 Units (100, 200, and 300 Units). This had the potential to affect 55 of 55 residents who reside in the	F0520	1. Residents #1, #3, #12, #13, #23, #24, #51, #55, #56, #48 and #67 had no adverse affects noted. Quality Assurance (QA) Committee will be notified of infection control system failure not being identified by the QA Committee.2. Residents residing at this facility have potential to be at risk of alleged deficient practice. QA Committee will develop systems to be reviewed monthly to ensure system failures can be identified. Action Plans will be implemented for systems	01/20/2013

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	the facility. (Residents #1, #3, #12, #13, #23, #24, #48, #51, #55, #56, and #67) (LPN #3, LPN #4, CNA #5, RA #6, CNA #8, Cook #10, LPN #12, RN #13, RN #14, RN #15, and Dietary Manager) Findings include: 1. During an observation on 12/13/12 at 7:33 a.m., RN #13 obtained Resident #1's blood pressure with a digital wrist cuff and also obtained the resident's oxygen saturation with the facility's oximeter. RN #13 then left the resident's room and placed both the blood pressure cuff and oxemeter in a basket on top of the medication cart. RN #13 did not sanitize the items prior to placing the items in the basket. 2. During an observation on 12/14/12 at 10:03 a.m., LPN #4 listened to Resident #67's breath sounds and obtained the resident's oxygen saturations with the facility's oxemeter. The stethoscope was then placed around the back of LPN #4's neck, and LPN #4 then left the resident's room without washing her hands or sanitizing the oxemeter. LPN #4 then placed the oxemeter in a		identified which include who will monitor and compliance date.Staff in each department will be in-serviced on proper handwashing practices. Nursing staff will be in-serviced on proper cleaning techniques of equipment for multi-resident use, proper storage of items that belong to individual residents in resident rooms and in treatment carts and education to nursing staff related to dedicated equipment for residents in isolation. 3. Director of Health Services (DHS) or designee will conduct rounds on units at various times to include checking resident bathrooms and treatment carts for proper storage of personal items, observation of proper handwashing practices during meals, care and medication pass, observation of proper cleaning of equipment used by multiple residents and those residents in isolation. Rounds will be conducted 5x's/week x 1 month, then weekly x 5 months. 4. Audit results will be brought to monthly QA meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved. Results will also indicate to QA Committe if in-services are effective. If results indicate they are not then in-services will be re-developed and implemented until 100% compliance is achieved.	

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	basket on top of the medication cart and began looking through her Medication Administration Records and pulled the medication cart down the hallway. During an interview on 12/14/12 at 10:06 a.m., LPN #4 indicated she washed her hands every three residents and use alcohol gel between residents. She indicated she had just touched the stethoscope, so that is why she did not wash her hands. She indicated she sanitizes her stethoscope with alcohol every morning. She indicated she was unsure what the policy was for sanitizing the stethoscope and oxemeter. She indicated she does not sanitize the stethoscope and oxemeter between residents. She indicated it would be a good idea if the items were washed between residents. She indicated if the resident was really sick she would wipe the oxemeter finger probe with alcohol gel. An undated facility policy, titled, "Stethoscope Cleaning Guidelines", received as current from the Administrator on 12/14/12 at 11 a.m., indicated, "...To prevent cross contamination when using a stethoscope between residents			

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	and/or when a stethoscope is used by multiple staff members...Gather disposable alcohol wipes or a bottle of alcohol and cotton balls to clean the stethoscope...Using firm pressure, clean the stethoscope ear pieces, tubing, diaphragm and bell in a circular motion with alcohol wipe or alcohol socked (sic) cotton ball..." 3. On 12/13/12 at 4:00 p.m., LPN #3 was observed assessing Resident #67 with her own stethoscope and placed it back around her neck then applied a pulse oximeter probe around the resident's finger. LPN #3 left the room and placed the pulse oximeter machine back in basket with other equipment without being cleaned. LPN #3 had placed Resident #67 nebulizer machine on the floor while the resident was receiving treatment. LPN #3 left the room again and returned to Resident #67's room with an ear thermometer and took the resident's temperature in her ear. LPN #3 then disposed the cover in the bathroom and left the room without cleaning the thermometer and washing hands.			

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	LPN #3 came back into the room to ask the resident if she wanted Tylenol, returned back to medication cart, went back to the resident's room and asked her about her pain intensity, went back to the medication cart and returned to the resident's room to give the Tylenol and restarted the nebulizer. LPN #3 left the room without cleaning any equipment, her stethoscope, or washing her hands. LPN #3 then went to Resident #60's room and checked the resident's blood pressure with an electric, wrist monitor and put the monitor back in basket with other equipment on the medication cart without cleaning it. LPN#3 then prepared Resident #60's medication and took it to the resident. At this time, LPN #3 washed her hands. LPN #3 was then observed to return to her medication cart, go into Resident #13's room, then went back to Resident #67's room and returned to her medication cart. LPN #3 was then observed to remove a bag of trash on the side of the cart. LPN #3 had gone back to the medication cart, grabbed the pulse oximeter machine and placed it under			

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	her arm. LPN #3 returned to Resident #13's room, put the head of bed up, gave medication and put the head of the bed back down. She left the room without washing her hands and grabbed the pulse oximeter from under her arm and gone into Resident #67's room. LPN #3 then removed Resident #67's mask, placed it back into the bag and placed the nebulizer machine back on the table. The pulse oximeter was laid on the resident's chair while she assessed the resident's lung sound with her stethoscope again. LPN #3 put the stethoscope back around her neck without washing it. LPN #3 placed the pulse oximeter on the resident's bedside table, assisted the resident to the bathroom. LPN #3 did wash her hands but she brought the pulse oximeter back out to the medication cart and didn't clean it. 4. LPN #4 was observed on 12/14/12 at 9:54 a.m., to go into Resident #67's room and turned off the nebulizer machine. LPN #4 assessed the resident lungs with her stethoscope and walked out of room without washing hands or cleaning the stethoscope. The pulse oximeter was used on the resident and was placed back into the basket on the			

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	medication cart without being cleaned. An undated facility policy, titled, "Pulse Ox Cleaning Guidelines", received as current from the Director of Nursing (DoN) on 12/14/12 at 11 a.m., indicated, ""...To prevent cross contamination when using a Pulse ox between residents and/or when a stethoscope (sic) is used by multiple staff members...Gather disposable alcohol wipes or a bottle of alcohol and cotton balls to clean the Pulse ox...Using firm pressure, clean the Pulse ox, wires, probe in a circular motion with alcohol wipe or alcohol socked (sic) cotton ball..." 5. During an interview on 12/14/12 at 10:55 a.m., The DoN indicated the resident's in isolation have their own blood pressure cuff and equipment. She indicated they are either kept in the room or in the drawer in the isolation dresser. During an observation of Resident #48's room, with the Nurse Consultant present, there were no blood pressure cuff and stethoscope located in the room or in the isolation dresser. During an interview at the time of the			

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	observation, the Nurse Consultant indicated the resident had Clostridium Difficile (C-Diff). During an interview at the time of the observation, LPN #4 indicated she takes the blood pressure cuff into the room to get the resident's blood pressure. She indicated she had asked for a blood pressure cuff and stethoscope for the resident but they were never available for the resident. She indicated she cleaned her stethoscope with alcohol after she used it for the resident. She indicated she did not sanitize the blood pressure cuff. An undated policy, received from the DoN as current on 11/14/12 at 1:10 p.m., titled, "Contact Precautions", indicated, "...Contact Precautions are indicated to prevent and control nosocomial transmission of infection with any of the following:...Clostridium Difficile...Procedure...Dedicated equipment per resident or the cleaning of equipment between residents is required...A stethoscope, sphygmomanometer (blood pressure cuff)...thermometer should be dedicated to individual residents. If use of common equipment is unavoidable, then adequate cleaning and disinfecting is necessary before			

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	use with other residents..." 6. During an observation on 12/11/12 at 11:19 a.m. Resident #23's bathroom contained a toothbrush in a plastic cup with bristles uncovered sitting on the bathroom sink (shares bathroom with another resident). During an interview at the time of the observation the resident stated the toothbrush was hers. She stated there was no other place to keep them. During an observation on 12/17/12 at 1:25 p.m. with the Maintenance Director and the Director of Housekeeping, Resident #23's bathroom contained a toothbrush in a plastic cup with bristles uncovered sitting on the bathroom sink. 7. On 12/11/12 at 10:09 a.m., Resident #55 and #56's tooth brushes were observed in the bathroom, on a table, uncovered in a cup. A white measuring collection hat was observed behind the toilet on the floor, uncovered. On 12/13/12 at 9:21 a.m., Resident #55 and #56's tooth brushes were observed in the bathroom on a table, uncovered, next to the toilet. A			

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	package of incontinent briefs was observed on the floor opened, next to the toilet. A white measuring collection hat was observed behind the toilet on the floor, uncovered. On 11/14/12 at 11:00 a.m., Resident #55 and #56 toothbrushes was observed on in the bathroom on a table, uncovered, next to the toilet. A package of incontinent briefs was observed on the floor opened, next to the toilet, and a soiled washcloth observed on bathroom floor. 8. During an observation of the 200 Unit Treatment Cart on 12/17/12 at 2:43 p.m., with LPN #12 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. LPN #12 acknowledged the tubes were not stored in a sanitary manner. During an observation of the 100 Unit Treatment Cart on 12/17/12 at 3:03 p.m., with RN #14 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. RN #14 acknowledged the tubes were not stored in a sanitary manner.			

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	During an observation of the 300 Unit Treatment Cart on 12/17/12 at 3:07 p.m., with RN #15 present, there were numerous opened/used tubes of skin protectant ointments with resident names on tubes, touching each other in the bin of the treatment cart. RN #15 acknowledged the tubes were not stored in a sanitary manner. 9. During dining observation in the Main Dining Room, on 12/11/12 at 12:25 P.M.,Cook #10 was serving plates at the steam table without the use of gloves when she went into the kitchen by pushing the swinging door open with her bare left hand. Cook #10 returned and continued to serve food onto plates without washing her hands or without using the antibacterial gel which is mounted to the wall next to the kitchen door. Cook #10's bare thumbs were observed to be on the topside of each plate as she was serving the food. On 12/11/12 at 12:34 P.M., Cook #10 was again observed to leave the serving line to enter the kitchen pushing the door open with her bare hand. She returned to serving plates without washing her hands or using antibacterial gel.			

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	On 12/11/12 between 12:35 p.m. to 1:00 p.m., the DM (Dietary Manager) was observed to have touched a resident while placing a clothing protector on them and went to the steam table, picked up a tray of food and passed it out to the residents. The DON was observed coming into dining room and began passing out trays to residents in the smaller dining room and did not wash her hands/use hand sanitizer prior to passing out the tray of food. The DM was observed to have her hand on resting on the top of her head while holding a tray, walked to the fluid area, grabbed a glass, walks into the kitchen. The DM came out with milk in a glass and delivered it to a resident. The DM bends over speaking to a resident and touches her legs, grabs another glass off of the table, walked to the fluid area, fills the glass with juice and returns it to the resident. Again, she touches her legs, took a plate off of a table and took it to a counter, cuts up the food on the plate and returns it to the resident. The DM touches a resident's wheel chair, touches another resident and then washes her hands. On 12/11/12 at 12:44 P.M., the Dietary Manager (DM), who was assisting in delivering plates by tray,			

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	was observed going into the kitchen using her bare hands on the door. The DM came out of the kitchen holding individual serving size dishes in her hand. Without washing her hands or using antibacterial gels, the DM proceeded to serve plates with bare hands. On 12/11/12 at 12:49 P.M., the DM went into the kitchen, opened the door with her bare hands and returned with a glass of liquid. She proceeded to continue serving with no hand washing or gel. On 12/11/12 at 12:53 P.M., Cook #10 went into the kitchen using her bare hand on the door and came out with a stack of clean dishes. She proceeded to serve food onto plates without washing her hands or using gel. 10. On 12/13/12 at 8:45 a.m., RA #6 (Restorative Aide) was observed assisting a Resident #12 up in the wheelchair and then started to pass out a breakfast plate to Resident #51. RA #6 then repositioned Resident #1 in her wheel chair and began passing out another breakfast plate to 2 other residents. RA #6 then repositioned Resident #12's wheel chair under the table, put on clothing protector on the			

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	resident, then sat down between Resident #24 and #12. RA #6 began to assist Resident #24 with breakfast and turned around and wiped of Resident's #12 mouth. At this time did RA #6 got up and sanitized her hands. CNA #5 came into the small dining room and picked up a plate of food and delivered it to Resident #13 and began to assist her with her meal. CNA #5 wiped Resident #13's mouth off with a towel, clipped wheel chair alarm to the resident and began to assist Resident #1 by cutting up a cinnamon roll. CNA #5 returned to Resident #13 and wiped off her face and left to go to the kitchen to get another bowl of oatmeal for Resident #1. CNA #5 returned with a bowel of oatmeal, moved a chair from Resident #13's table to Resident #3 table and sat in between Resident #3 and #51. CNA #5 then got up and walked over to Resident #55 and cut up her cinnamon role. CNA #5 then started to cut Resident #51's cinnamon role. CNA #8 came into dining room, sanitized her hands, cut up a cinnamon role for Resident #56 then repositioned Resident #3, then removed dishes from Resident #12.			

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	CNA #8 sanitized her hands, removed Resident #51 clothing protector, removed the resident from the dining room. Resident #3 asked for a glass of milk and CNA #8 took the glass from the table and returned with milk. CNA #8 did not sanitize her hands. When CNA #8 did sanitize her hands, she removed a clothing protector from Resident #56, touched the residents wheel chair, then touched Resident #3 plate to encourage the resident to eat. RA #6 and CNA #8 were interviewed during this time. Both indicated hand washing or sanitizing should be done in between each resident contact. During an interview on 12/14/12 at 2 p.m., the Director of Nursing indicated the facility had inservices on hand washing, and the last one had been 10/17/12. She indicated she and the ADON does rounds to monitor infection control practices and she does tracking and trending of active infections. She indicated there had been no audits to ensure hand washing was being done and being done correctly. She indicated there is no follow-up to ensure the inservices are effective. 3.1-52(b)(2)			

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R0000	The following State Residential findings cited are in accordance with 410 IAC 16.2.	R0000	Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. Please acccept this plan as same and our credible allegation of compliance.White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.	

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R0241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review and interview, the facility failed to ensure physicians' orders were followed, related to medications not held as ordered, medications not given as ordered, weights not completed as ordered, oxygen not administered as ordered, and laboratory (lab) tests not completed as ordered for 3 of 6 residents reviewed for physicians' orders in a total sample of 6. (Residents #105, #124, and #132) Findings include: 1. Resident #132 record was reviewed on 12/18/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and osteoporosis. The Physician's Recapitulation Orders, dated 12/12, indicated an order for a BMP (Basic Metabolic Panel) (electrolytes) every six months and alternate with a CMP	R0241	1. Resident #95 received his lunch during the time of the survey. He ordered a "special" that was prepared in the kitchen and, therefore, didn't need to receive any food from the steam table. Resident #24 was provided clean pants during the time of the survey. No adverse affects were noted.2. Residents receiving meals in the dining room have the potential to be affected by the alleged deficient practice. Dietary and Nursing staff will be in-serviced on verifying residents present in the Dining Room receive their food before the food is removed. Nursing staff will also be in-serviced on dignity issues related to residents' hair being combed and clothing not being soiled. 3. Meal Manager or designee will conduct audits 3x's/week x 1month, then weekly x 5 months to ensure all residents in the Dining Room receive food prior to food being removed and that residents are in unsoiled clothing with combed hair. 4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed	01/20/2013

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	(Comprehensive Metabolic Panel) (more comprehensive electrolyte test) every six months, lipid panel every six months, and a fasting iron panel every three months. The record indicated the last lab tests were completed on: lipid panel completed was on 10/27/11 fasting iron panel was on 11/13/11 BMP was on 11/14/11 then on 8/24/12. There was a lack of documentation a CMP had been completed on the resident During an interview on 12/18/12 at 2:30 p.m., the Medical Records LPN indicated the labs had not been obtained as ordered. 2. Resident #124's record was reviewed on 12/18/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and pulmonary fibrosis. The Physician's Recapitulation Orders, dated 12/12, indicated an order, dated 09/20/12 for daily weight		by QA Committee x 6 months or until 100% compliance is achieved.	

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	and report edema or a weight gain of 11 pound or loss of 6.6 pounds to the Nephrologist. The Vital Signs and Weight Record indicated the resident's weight had been obtained on 10/12 and 11/12. There was a lack of documentation to indicate the resident's weight had been obtained daily as ordered. During an interview on 12/18/12 at 10:10 a.m., LPN #16 indicated the resident gets weighed at dialysis three times a week. She indicated a daily weight was not getting done at the facility. 3. Resident #105's record was reviewed on 12/18/12 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia, atrial fibrillation, and anemia. A) The Physician's Recapitulation Orders, dated 12/12, indicated the resident was to receive a CMP and a CBC (complete blood count) every three months. The last CBC results in the record was dated 08/21/12. There was a lack of documentation in the record to indicate a CMP had been completed.			

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	During an interview on 12/18/12 at 11:40 a.m., LPN #16 indicated the CBC's and CMP's had not been completed as ordered. B) The Physician's Recapitulation Orders, dated 12/12, indicated an order (10/28/11) for verapamil (heart medication) 240 milligrams daily, hold the medication if the pressure is less than 100/50 or the pulse is less than 60. The Medication Administration Record (MAR), dated 10/12, indicated the resident's blood pressure and pulse had not been obtained on October 1, 2, 3, 6, 7, 15, 16, 18, 22, 24, 26, 27, 28, 29, 2012. The 10/12 MAR indicated the resident's pulse had not been obtained on October 10, 14, 17, 19, 20, and 21, 2012. The 10/12 MAR indicated the resident's blood pressure was 88/54 on 10/10/12 and the verapamil had been administered. The MAR, dated 11/12, indicated the resident's blood pressure and pulse had not been obtained on November 1, 3, 4, 5, 7, 13, 14, 15, 19, 22, 23, 27, 28, and 29, 2012.			

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	The 11/12 MAR indicated the resident's pulse had not been obtained on November 2, 21, 24, 25, and 26, 2012. The 11/12 MAR indicated the resident's pulse was 58 on 11/8/12 and the verapamil was given and the blood pressure was 92/50 on 11/17/12 and 98/48 on 11/18/12 and the verapamil had been administered. The MAR, dated 12/12, indicated the resident's pulse had not been obtained on December 1, 2, 3, 5, 8, 9, and 11, 2012. During an interview on 12/18/12 at 11:15 a.m., LPN # 16 indicated the blood pressures and pulses had not been obtained as ordered. She indicated the verapamil may have been held on November 8, 17, and 18, 2012 and she just didn't circle the initials (indicates medication not given) on the MAR. She indicated she could not remember. During an interview on 12/18/12 at 11:15 a.m., QMA #17 indicated she should have held the verapamil on 11/8/12 when the resident's pulse was 58.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C) During the initial tour on 12/11/12 at 9 a.m. with CNA #18, Resident #105 was sitting in the lounge. The resident did not have oxygen on. During an observation on 12/18/12 at 9:15 a.m., the resident was in his wheelchair in his room. The resident did not have oxygen on. The Physician's Recapitulation Orders, dated 12/12, indicated an order for oxygen at 2 liters per minute continuous. During an interview on 12/18/12 at 11:15 a.m., LPN #16 indicated the resident should have his oxygen on. During an observation on 12/18/12 at 12 p.m., the resident was sitting in the lounge and did not have his oxygen on. D) Resident #105's Physician Recapitulation orders, dated 12/12, indicated an order (10/28/11) for timolol (glaucoma) eye drops, one drop in both eyes daily. The MAR, dated 11/12, indicated the resident had not received the eye drops on November 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 16, 19, 20, 21, 22, 23, 24, 25, and 26, 2012.			

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	155782	A. BUILDING 00 B. WING	12/21/2012

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	The MAR, dated 12/12, indicated the resident had not received the eye drops on December 2, 3, 4, 11, 12, 13, 14, 15, 16, 17, and 18, 2012. During an interview on 12/18/12 at 11:15 a.m., LPN #16 indicated the eye drops were not signed as given.			

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R0246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure a QMA received authorization to give an as needed (PRN) medication prior to administering the medication for 2 of 6 residents reviewed for PRN medication in a total sample of 6. (Residents #105 and #107) (QMA #15, #17, and #19) Findings include: 1. Resident #105's record was reviewed on 12/18/12 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia, atrial fibrillation, and anemia. The Physician's Recapitulation Orders, dated 12/12, indicated an order (8/14/12) for albuterol (breathing medication) 0.83% per nebulizer every four hours as needed, (07/26/12) ipratropim BR	R0246	1. Resident #105 and #107 had no adverse affects noted. 2. Residents receiving medications from facility staff have potential to be at risk of alleged deficient practice. Qualified Medication Aides (QMAs) will be in-serviced to obtain prior authorization by licensed nurse prior to administering medication.3. Nurses and QMAs will be in-serviced on the requirement of obtaining authorization by the licensed nurse in order for the QMA to administer PRN medications. Documentation will be done to indicate authorization has been provided. Director of Health Services (DHS) or designee will audit Medication Administration Records (MARs) 5 x's/week x 1 month, 3x's/week x 1 month and weekly x 4 months to ensure proper authorization is obtained. 4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or	01/20/2013

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	(breathing) 0.02% per nebulizer four times a as needed, and (5/ 25/12) anti-diarrhea 2 milligrams (mg) one tablet orally as needed with a maximum of 16 mg in a day. The Medication Administration Record (MAR), dated 09/12, indicated QMA #15 gave the as needed anti-diarrhea on 09/01/12, the ipratropim on September 5, 26, and 29, 2012, and the albuterol on September 5, 26, and 29, 2012. There was a lack of documentation to indicate the QMA had obtained authorization from a licensed nurse prior to the administration of the medications. The MAR, dated 10/12, indicated QMA #15 administered the as needed albuterol and ipratropim on 10/8/12 without prior authorization of a licensed nurse prior to the administration of the medication. The MAR, dated 12/12, indicated QMA #19 administered the as needed albuterol on December 6 and 14, 2012 and the anti-diarrhea on December 13, 2012 without prior authorization of a licensed nurse prior to the administration of the medication.		until 100% compliance is achieved.	

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	2. Resident #107's record was reviewed on 12/18/12 at 2 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia with psychosis. The Physician's Recapitulation Orders, dated 12/12, indicated orders for (4/9/12) acetaminophen 325 mg, two tablets as needed every 4-6 hours for pain or fever, Hydrocodone (pain medicine) 5/325 mg, one tablet every four hours as needed for pain, and lorazepam (anti-anxiety) 0.5 mg every 24 hours for severe breakthrough anxiety/agitation. The MAR, dated 11/12, indicated QMA #19 administered the hydrocodone on November 26, 28, and 29, 2012 and administered the lorazepam on November 13 and 25, 2012 without prior authorization of a licensed nurse prior to the administration of the medication. The MAR, dated 12/12, indicated QMA #17 administered the acetaminophen on December 7, 10, and 14, 2012 without prior authorization of a licensed nurse prior to the administration of the medication.			

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	During an interview on 2:05 p.m., QMA #19 indicated she did not think she needed to have prior authorization in an Assisted Living facility.			

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R0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident received a yearly tuberculin (TB) skin test (test for tuberculosis) for 1 of 6 resident's reviewed for TB tests in a total sample of 6. (Resident #132) Findings include: Resident #132 record was reviewed on 12/18/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and osteoporosis.	R0410	1. Resident # 132 will have physician notified that annual tuberculin (TB) test was missed in 2012. Family will also be notified. No adverse affects were noted.2. Residents residing at facility have potential to be at risk of alleged deficient practice. Charts of current residents will be reviewed for compliance with TB tests. Any residents identified as out of compliance will have physician notified and orders obtained and followed.3. Licensed Nurses will be in-serviced on requirements for TB tests. Director of Health Services (DHS) or designee will	01/20/2013

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	The Immunization Record indicated the resident received her first step TB test on 10/24/11 and a second step TB test on 11/09/11. The record lacked documentation to indicate the resident had received a yearly TB test by in 2012. During an interview on 12/18/12 at 2:30 p.m., the Medical Records LPN indicated the TB test had not been completed yearly.		audit charts monthly x 6 months for compliance with TB tests. New admissions will be audited upon admission for proper TB test implementation x 6 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committe x 6 months or until 100% compliance.	